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Joe Leean
Secretary

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March 7, 2000

Mike Fiore, Director
Center for Medicaid and State Operations
Family and Childrens' Health Program Group
Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD **21244-1850**

Dear Mike Fiore:

Thank you for your questions and suggestions regarding the State of Wisconsin's proposal for a Section **1115** demonstration to provide family planning services to its residents. We have reviewed the questions and are submitting our answers.

Enclosed with this letter is a revised Budget Neutrality Worksheet, a document with your questions and our answers, and attachments that support our answers. Please review them and let us know if you have any questions.

We look forward to expanding our family planning program. As stated in our waiver request, providing family planning services to the target population will be cost effective. If you have questions regarding our responses, you may contact Mary Laughlin at (608) **261-7833.**

Sincerely,

Peggy **L.** Bartels
Administrator

PLB:mhy
PA02066.PA

Enclosures

FAMILY PLANNING WAIVER RESPONSES TO HCFA

Budget Neutrality

1. See attached Budget Neutrality worksheet. We used HCFA's template.

2. A.) Since the target population excludes Badgercare, S-CHIP and Healthy Start eligibles, the with and without waiver budget should not include these population groups.

   Badgercare, S-CHIP and Healthy Start eligible persons were not included in either the with or without waiver budget (See Appendix A.). Badgercare is Wisconsin's Medicaid expansion for children and their parents, through the S-CHIP program for children, and a Medicaid expansion for uninsured parents of children, authorized through a $1115(a) demonstration project waiver. Badgercare eligibles were subtracted from the estimate of potential enrollees for the Family Planning Benefit.

   As there is potential for expansion of the Badgercare program during the next 2-year period, the number of women served through the Family Planning waiver may decrease slightly (see question 4 under "Target Population"). Medicaid eligibles that were subtracted from the same estimate include Wisconsin Healthy Start eligibles. Wisconsin's Healthy Start program covers pregnant women and children with higher income levels than regular Medicaid and has no asset limit.

   B.) If you plan to include cost savings beyond the first year of life in the calculation, please provide a justification.

   We are including savings beyond the first year of life. The reason for this is that a child born to a woman in the income group covered by the waiver would most likely be eligible for Medicaid/BadgerCare benefits beyond its first year.

   In Wisconsin, Badgercare covers children and their parents with family income at or below 185 percent of the Federal Poverty Level (FPL) and until family income exceeds 200 percent of FPL. Children born to the target population of the waiver will be qualified for Badgercare benefits until their family income increases to 200 percent of the FPL. We believe that it is not likely that the family income will increase significantly following the birth of a baby to a low-income woman. Even if the income increases slightly, the family will still be eligible for Badgercare.

Financial/Services

1. Please explain your plans for claiming FFP for administrative activities associated with this waiver. FFP for administrative activities associated with family planning services is available at the 50 percent matching rate. FFP at the 90 percent rate is limited to expenses associated with providers offering, arranging *AND* furnishing family planning services as specified in section 1903(a)(5) of the Social Security Act.

   Administrative activities for which FFP will be claimed at the 50 percent matching rate include: eligibility determinations, systems development and administration, and Forward ID Cards. This is no different than current claiming, and it will be handled the same way.

Administrative activities for which FFP will be claimed at the 50 percent matching rate include: eligibility determinations, systems development and administration, and Forward ID Cards. This is no different than current claiming, and it will be handled the same way.

2. **Please explain the use of transportation services for women in this demonstration.**

To make services under this demonstration project accessible, Wisconsin will cover transportation, both common carrier and specialized medical vehicle **(SMV),** for those who qualify. Common carrier will be claimed as an administrative service at 50 percent FFP; **SMV** as a Medicaid benefit at 59 percent FFP.

3. **The proposal included a lengthy list of services that will be provided to enrollees in the demonstration. We would like to engage in a more detailed discussion regarding the services to be provided under this waiver and the associated matching rates.**

The list of CPT codes included in the waiver application (in Appendix I) are allowable within the context of a family planning visit (a visit with a family planning diagnosis code). The key is the delivery of contraceptive services – or other medical services related to the delivery of contraceptive services – as with regular medical guidelines, and as allowed within the national Title X family planning program.

Confidentiality

1. **What are the current confidentiality protections afforded to Medicaid beneficiaries?**

The DPH Maternal and Child Health Advisory Committee's Reproductive Health Privacy Project, in conjunction with the DPH, completed a resource guide for the Wisconsin Family Planning Program: "Patient Rights and Provider Responsibilities: Privacy and Confidentiality Issues for Family Planning and Reproductive Health Services." (See attached "Patient Rights and Provider Responsibilities.") The following references from that document outline confidentiality guidelines for the Wisconsin Family Planning Program. These guidelines are consistent with the Wisconsin Medicaid confidentiality guidelines.

- I. Wisconsin Laws Protecting Confidentiality (p. 2-9). This section discusses Wis. Stat., 146.81-146.83, on health care records. It provides a definition of a "patient health care record." It explains that patient health care records cannot be released without the informed consent of the patient or **a** person authorized by the patient. "Informed consent" is defined. It defines "medical privilege." It outlines the "Family Planning" information in Wis. Stat., 253.07(3)(c). Specifically regarding confidentiality of family planning it states that Section 253.07(3)(c) provides:

> All information gathered by any agency, entity or person conducting programs in family planning, other than statistical information compiled without reference to the identity of any individual or other information which the individual allows to be released through his or her informed consent, shall be considered a confidential medical record. (See also Administrative Rule HFS 151.03(2)(d)).

No other exceptions to informed consent except for statistical information are specified. This section also discusses statutory protections relating to examination, diagnosis and treatment of sexually transmitted diseases (STDs).

- 11. Wisconsin Laws Requiring Disclosure (p. 9-14). This section discusses s. 48.981, Wis. Stats., regarding suspected child abuse and neglect. It states that:

  Health professionals, including nurses and physicians, as well as social workers, who have reasonable cause to suspect that a child seen in the course of professional duties has been abused or neglected...or threatened with abuse and neglect...must report to authorities. S. 48.981(2), Wis. Stats.

  The next subsection discusses allowing children to obtain confidential health care services and refers to s. 48.981(2m)(a) and (b), Wis. Stats. It states:

  Certain health care providers including physicians, physician assistants and nurses (but not social workers) are permitted an exception from the reporting requirement for sexual contact, if they provide family planning services (as defined in s. 253.07(1)(b), Wis. Stats.), pregnancy testing, obstetrical health care or screening, or diagnosis and treatment for sexually transmitted diseases.

The above exception from the reporting requirement also applies to any person who obtains information about a child who is receiving or has received family planning services and/or other clinic staff and public health personnel who receive STD reports.

Circumstances where this exception does not apply are listed:

a. where sexual intercourse or contact involves a caregiver,
b. when the child suffers from mental illness or deficiency which renders the child temporarily or permanently incapable of understanding or evaluating the nature or consequences of his or her actions,
c. in situations where the age or immaturity of the child renders him or her incapable of understanding the nature or consequences of sexual intercourse or contact, that the child was unconscious during the act or otherwise incapable of communicating unwillingness to engage in the activity,
d. that another participant in the conduct was engaging in sexual exploitation of the child, or
e. if there is any reason to doubt the voluntariness of the child's participation.

- Electronic Records and Databases-Special Considerations. This section discusses the fact that public agencies--whether state, federal or local-risk violation of constitutionally protected rights (and civil rights sanctions) if confidential information is disclosed or disseminated electronically. In a discussion of "internal access" of personnel in family planning agencies it states:

Personnel whose responsibilities do not include family planning, obstetrical and gynecological services, pregnancy testing and counseling or examination, diagnosis and treatment of sexually transmitted diseases should not have access to information or records about these services areas, (p. 15).

Regarding external access to electronic data at family planning clinics, it suggests the following types of provisions be included in contracts:

1. Written assurances that the contractor's employees will be disciplined for any unauthorized disclosure or transmission of information and for altering or destroying information and that, if willful, the employee will be discharged (include assurance that such employees have notice of this policy).

2. Written agreement that the outside contractor or individual consents to immediate injunctive relief against them, with damages and costs of bringing action, in the event that unauthorized disclosure occurs or is threatened or likely to occur without such judicial relief, (p. 16).

- Federal Laws - This section discusses federal regulations of the Medicaid program and Title X, Family Planning.

2. How **do confidentiality protections apply to minors?**

See the above discussion on "Wisconsin Laws Requiring Disclosure." Children are allowed to obtain confidential health-care services in certain circumstances. Refer to s. 48.981(2m)(a) and (b), Wis. Stats.:

Certain health care providers, including physicians, physician assistants and nurses (but not social workers), are permitted an exception from the reporting requirement for sexual contact if they provide family planning services (as defined in s. 253.07(1)(b), Wis. Stats.), pregnancy testing, obstetrical health care or screening, or diagnosis and treatment for sexually-transmitted diseases.

The above exception from the reporting requirement also applies to any person who obtains information about a child who is receiving, or has received, family planning services and/or other clinic staff and public health personnel who receive STD reports.

Circumstances where this exception does not apply are listed:

f. where sexual intercourse or contact involves a caregiver,
g. when the child suffers from mental illness or deficiency which renders the child temporarily or permanently incapable of understanding or evaluating the nature or consequences of his or her actions,
h. in situations where the age or immaturity of the child renders him or her incapable of understanding the nature or consequences of sexual intercourse or contact, that the child was unconscious during the act or otherwise incapable of communicating unwillingness to engage in the activity,

i. that another participant in the conduct was engaging in sexual exploitation of the child, or

j. if there is any reason to doubt the voluntariness of the child's participation.

Wisconsin Medicaid assures confidentiality to minors receiving family planning services by utilizing a confidentiality flag mechanism in its electronic database system. Family planning services are flagged so that they are not included in periodic Explanation of Benefits (EOB) letters sent out to policy recipients.

Eligibility/Presumptive Eligibility

1. **Please provide a detailed description of the presumptive eligibility process. Discuss which providers will be utilizing presumptive eligibility and whether a negative pregnancy is the only mechanism to access the presumptive eligibility process.**

One of the key components of this demonstration project is making services available to women when they most need the services and are willing to accept them. Consequently, Wisconsin will provide one period of presumptive eligibility (PE) per calendar year for women who are eligible for services under this demonstration project. The PE period will extend from the date of application, plus two calendar months after the application month. With PE, women who request pregnancy tests, and get a negative result, will be able to receive immediate Medicaid-covered family planning counseling and services. If the women are asked to apply for program eligibility before receiving family planning counseling and services, many of them will fail to follow through, and the opportunity to provide these services will be lost. The two-month PE period is designed to allow adequate time for the women to formally apply for Medicaid eligibility under the demonstration project and have eligibility determined within a 30 day period.

Presumptive Medicaid Eligibility begins on the day on which a qualified provider determines whether the woman meets the criteria by completing a PE application. The provider submits the application to Wisconsin Medicaid within five days.

Wisconsin has provided PE for pregnant women since 1987 and will build upon this successful network of PE providers to reach women who may be eligible for family planning services. The Medicaid program will establish similar provider certification procedures for family planning and will allow all current PE providers to provide family planning as well. PE will facilitate access to the demonstration project for women who have not previously been involved with Medicaid. Providers will include physicians, nurse midwives, nurse practitioners, FQHCs, hospital clinics and pharmacies. All Title V and Title X family planning clinics will be providing services under this demonstration project and may become qualified to make PE determinations.

The negative pregnancy test was given as an example of the importance of providing services to women when they are most in need of them and most willing to accept them. This is not the only situation in which a provider will complete a PE determination. Any woman requesting family planning services from a qualified provider will have her presumptive eligibility for Family Planning Services determined.

2. **Will women applying for State health or welfare programs, other than the waiver, also be evaluated for eligibility for the waiver (p. 12)? Describe the process to coordinate applications and referrals.**

Yes. The Family Planning Waiver program will build upon the structure that supports the Medicaid and Badgercare programs, with county and tribal economic support workers processing applications, using the Client Assistance for Reemployment and Economic Support (CARES) system which collects necessary information through an interactive process and then determines eligibility on-line.

- CARES is Wisconsin's automated system that determines eligibility for W-2, Medicaid, child-care assistance, food stamps and Badgercare. It will be used to determine eligibility for the Family Planning Waiver program.

- The CARES system will determine FPW eligibility after the individual has been determined to be ineligible for Wisconsin Medicaid and Badgercare.

- Every effort will be made to simplify the application and eligibility determination processes. We will use automated letters, simplified application forms, non-face to face application and review processes, and reduce verification requirements for this program.

- Eligibility information will be transmitted to the MMIS through the CARES/MMIS interface subsystem, just as it currently is for Medicaid and Badgercare.

- The MMIS uses the Medicaid eligibility data to issue the magnetic stripe Forward Card which acts as the Medicaid ID card, and process claims.

Before a woman can qualify for the Family Planning Waiver program, they must be tested for Medicaid and Badgercare eligibility. Those persons who qualify for Medicaid or Badgercare will be automatically enrolled in either program and will not be enrolled in the Family Planning Waiver program.

3. **How soon will the State's planned expansion of outstationed eligibility workers be completed?**

Wisconsin's expansion of outstationing will be completed by the end of 2000. Presently, there are eight Wisconsin counties whose outreach and outstationing efforts are receiving additional administrative funding. They are:

- Dane
- Fond du Lac
- Kenosha
- Lacrosse
- Milwaukee
- Monroe
- Oneida
- Sheboygan

Three counties, Milwaukee, Dane and Kenosha, have comprehensive Medicaid/BadgerCare outstationing programs and manage comprehensive service models. Each county has multiple application sites. The nature of the sites varies from public school locations to federally qualified health centers, to hospitals, to community centers, etc. The neighborhood populations are distinctly different and each county has effectively represented the mission surrounding outstationing – to provide immediate program access and immediate program eligibility determination.

Starting in July of 1999, DHFS expanded initial application receipt activities at the Healthy Start sites to include eligibility for family Medicaid and Badgercare. The sites include all Federally Qualified Health Centers and Disproportionate Share Hospitals throughout the state. There are presently 26 counties with this type of site. This activity was done as a demonstration leading to further expansion to other sites next year. (See attached "County Outstationing Map.")

Many other counties and some tribal agencies have outstationed eligibility staff using their existing administrative funds.

During 2000, other interested counties will be allowed to locate comprehensive Medicaid/BadgerCare outstations in their areas. There are at least two additional counties that have shown interest. Also, to further simplify the application process, a two-page application for Medicaid/BadgerCare will be available to all counties and organizations in those counties via the Internet.

4. **Will females under 19 otherwise eligible but not enrolled in S-CHIP or Badgercare be eligible for this demonstration?**

   Yes.

5. **Will women with other third party insurance be eligible for the demonstration? If *so*, will the demonstration or the third party health insurance be the primary payor?**

   Women with other third party insurance coverage will be eligible for the demonstration. Because third party insurance rarely pays for family planning services, Wisconsin does not require Family Planning providers to bill insurance companies first. Wisconsin's Medical Assistance Provider Handbook lists the services requiring health insurance billing. Family Planning services, drugs/supplies are not listed among those services. Medicaid is the primary payor for these services, and will be the primary payor for the demonstration project.

6. How will all of the family planning activities in the State be coordinated to carry out this waiver? Will the Department of Health and Family Services coordinate these activities with Title V, Title X, the Early Identification of Pregnancy program, Brighter Futures, Wisconsin Family Planning and Reproductive Health Association, and the State Medical Society?

   Wisconsin's Division of Public Health (DPH) will require coordinated agreements between its agencies and the community agencies that will process applications for this demonstration project. The existing system of services will be maintained to provide a foundation for expanding participation under this project (see map in Attachment 2). This system of statewide services provides the infrastructure through which increased awareness of and access to services can be accomplished statewide. The level of contraceptive services provided through this system of services will support expansion of services to achieve the objectives of this demonstration project. The Department of Health and Family Services will coordinate these activities with Title V, Title X, the Early Identification of Pregnancy Program, Brighter Futures, Wisconsin Family Planning and Reproductive Health Association, and the State Medical Society.

Evaluation

1. The State will work in consultation with HCFA to modify the initial evaluation plan to conform to HCFA's requirements.

   a. Who will conduct the evaluation and what are the evaluator's qualifications?

      The Office of Strategic Finance, within the Department of Health and Family Services, will be conducting the evaluation of the Family Planning Waiver program. The Office of Strategic Finance has staff who have expertise in program review and evaluation, and has conducted and participated in several Medicaid evaluation projects, including prenatal care coordination, Healthy Start, and Badgercare.

   b. Could the proportion of women be measured as opposed to the number of women?

      Yes.

   c. For hypothesis **1,** can a distinction be made between those women receiving family planning services through the regular Medicaid program and those receiving services through the waiver?

      Yes. Women receiving family planning services through the waiver will have a separate and distinct Medicaid status code. Hypothesis 1 will be modified to include only the target population of the waiver.

   d. For hypothesis **2,** can a distinction be made between women receiving family planning services through the demonstration and through regular Medicaid?

Yes. Women receiving family planning services through the waiver will have a separate and distinct Medicaid status code. Hypothesis 2 will be modified to include only the target population of the waiver.

e. For hypothesis 3, would it be possible to look at any birth in the last two years rather than just those paid by Healthy Start?

The Wisconsin Healthy Start population is a logical target population for the waiver, as women lose their eligibility for benefits after the 60" postpartum day. Because these women are low-income, have had a baby and lost their Medicaid benefits, they are at a higher risk of unintended pregnancy. These women are also easy to track through the system, Therefore, they make a good with and without waiver comparison regarding the rate of unintended pregnancy and associated costs.

For hypothesis 4, what is the baseline for the expected decrease in births?

The baseline for hypothesis **4** is the number of births to teens paid by Medicaid during the year prior to implementation of the waiver.

Outreach

1. Please provide an outreach and education plan.

The Early Identification of Pregnancy Program (EIDP) will be providing outreach and education for women eligible for the Family Planning Waiver benefit. The program has been awarded $100,000 in TANF funds to serve the Family Planning Waiver population. EIDP effectively reaches women who suspect they may be pregnant, and has demonstrated effectiveness in reaching low-income women, confirming pregnancy, and facilitating early entry either into prenatal care or into family planning services.

The EIDP program, authorized under s.253.085(2) of the statutes, provides early confirmation of pregnancy and timely and appropriate pregnancy-related care. EIDP services include outreach and public information, pregnancy testing, health risk assessment, education, and referral and follow-up for family planning and appropriate medical care. EIDP will provide outreach to the expanding family planning program as well as case management services to connect individual women to the services they need. When a woman comes to a family planning clinic for a pregnancy test, she will receive a physical exam, the test, and then, if she is pregnant, will be considered presumptively eligible and referred to Healthy Start. If she is not pregnant, she should receive counseling and explanation of the types of birth control available and a prescription for birth control, if necessary. Medicaid will pay for the exam, test, and the birth control, but the actual counseling and case management required will be funded by EIDP.

Provider Network/Training

1. **Has the State completed an assessment of the provider capacity to ensure access for the demonstration population? How many providers currently provide family planning services? How will the State continue to ensure that provider capacity will be adequate to meet the demand for service? Please provide a description of the providers that will participate in the demonstration.**

   As of 1999, there are family planning clinics in ***65*** counties in Wisconsin. (See Appendix H and attached description of Provider Service Areas and Clinic Locations.) All Medicaid-certified family planning clinics as well as all other Medicaid providers of maternal and child health services will be informed of the availability and extent of the waiver program through Medicaid provider publications.

   This notification will include not only providers who will supply direct services under this demonstration project, but also providers, like the prenatal care coordinators (PNCC) who have contact with the target population but do not provide family planning services. PNCC providers can be instrumental in encouraging former Medicaid/Healthy Start recipients to use the family planning services being offered under this demonstration project if they are not enrolled in Medicaid or Badgercare, and do not desire another pregnancy.

   PNCC program participation will be a key to successfully preventing subsequent pregnancies within this population. This program has direct access to women enrolled in Healthy Start, who are at a higher relative risk for an unhealthy pregnancy. Care coordinators will be able to facilitate timely post-partum contraception. Prenatal care coordination for women ineligible for Medicaid/Healthy Start will be funded under the statewide Title V, Maternal and Child Health Program. Training will be available to all prenatal care coordination providers statewide (Medicaid and Title V) to increase their skill in facilitating timely post-partum contraception.

2. **Please describe the process for training current and newly recruited providers and who will conduct the training.**

   As of January, 2000, the Division of Public Health has contracted with Health Care Education and Training, Inc. (HCET), to coordinate continuing education, training, and technical assistance for Wisconsin Family Planning Programs and their community service partners. The Wisconsin Coalition for Support Services Advisory Committee will be the pivotal mechanism to ensure that HCET, Inc., provides timely, practical and pertinent education, training and technical assistance services to the family planning providers in Wisconsin. (See attached description and overview of this project.) The purpose of the project is to improve and maintain the quality and cost-effectiveness of family planning and related reproductive health services through community-based family planning programs.

3. **How frequently does the State anticipate to conduct provider training?**

   Training will be offered as needed.

4. **Is** the deliverance of culturally competent care a component of the training?

Yes. Dr. Richard Aronson, a nationally known expert in cultural competence, will develop training for Family Planning providers. Dr. Aronson is the chief medical officer for maternal and child health in the Division of Public Health within the Department of Health and Family Services.

Target Population

1. Please explain why the State is only targeting women **15-44** rather than all women of childbearing age?

The Wisconsin Legislature specified that the waiver targets women in the 15-44 age range. During the 1996-1997 session of the Wisconsin Legislature, State Representative Tom Ourada and State Senator Russ Decker, introduced motions in the Joint Finance Committee (JFC) directing the Secretary of the DHFS to submit a Title XIX waiver expanding access to family planning services. Joint Finance Motion 1121 was for the development of

> ...a proposal to expand access to family planning services currently covered under the Medicaid program to all women between the ages of 15 and 44 who live in families with income under 185 percent of the federal poverty level. Direct DHFS to seek approval, by January 1, 1998, of a demonstration waiver from the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA), to implement this proposal. The demonstration project would be designed to test the effectiveness of innovative intervention strategies aimed at reducing the number of unintended pregnancies and improving birth outcomes among low-income women.

The Department will implement the project as soon as possible after the waiver is granted.

It is also important to note that 13 and 14 year-olds will be served with Title V, Title X and state Family Planning funds.

2. Please clarify the methodology for determining the target population. On the one hand, Wisconsin estimates that **47,000** women will be "potential eligibles" (p. **11)** while on the other hand, in Appendix C, there are **133,030** women between **20-44** under **185** percent of poverty. Some portion of the **133,030** will continue **to** be served by the Wisconsin Family Planning Program, but the portion might be different than **51** percent, since presumably some of the women eligible for the waiver were served by the Wisconsin Family Planning program. Please explain why the State assumes that participants in this family planning program **will** participate at the same rate **as** participants in the regular Medicaid program.

The Guttmacher data in Appendix C is included only to validate our calculations in Appendix A. The two numbers we compare are:

- Appendix A's 324,603 women at less than 185 percent FPL; and
- Guttmacher's 296,390 in need of publicly supported contraceptive services.

We also compare:

- Appendix A's: 189,350 women without Medical Assistance or Badgercare x 25 percent = 47,000 to
- Appendix C's: 86,493 (ages 20-44) + 74,559 (less than age 20) = 161,052 needing, but not receiving services from the Wisconsin Family Planning Program in 1995 x 25 percent = 40,263.

The two methodologies are different but produce similar numbers.

The assumption that the same rate of participation in the regular Medicaid/BadgerCare programs may be used for the rate of participation in the waiver program is based on the fact that the two populations have similar socioeconomic characteristics.

3. Since the Alan Guttmacher Institute estimates (Appendix C) of women in need of publicly supported family planning services includes women **13-14,** can Wisconsin adjust this estimate for the **13-14** year olds not targeted for the waiver?

Calculation of the estimated family planning users for the waiver program is contained in Appendix A. The estimate does not include 13-14 year olds.

4. Please provide a table including projections of women (numbers/proportions) eligible for each of the family planning programs (e.g., Wisconsin Family Planning Program, the waiver demonstration, regular Medicaid, Badgercare, Title V, and Title X) and how these will change over the lifetime of the waiver.

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
AFDC/Healthy Start	**46,725**	**147,659**	**148,612**	**149,584**	**150,576**
Waiver Demo.	**47,000**	**47,000**	**47,000**	**47,000**	**47,000**
BadgerCare	**25,100**	**33,000**	**33,000**	**33,000**	**33,000**
Title V	**35,000**	**35,350**	**35,704**	**36,061**	**36,422**
Title X	**40,000**	**40,400**	**40,804**	**41,212**	**41,624**

As there is potential for expansion of the Badgercare program during the next 2-year period, the number of women served through the Family Planning Waiver program may decrease slightly.

Administrative/Quality Assurance

1. **What quality assurance activities will the State conduct to ensure that enrolled beneficiaries are provided with quality services?**

   As of January 2000, the Division of Public Health has contracted with Health Care Education and Training, Inc. (HCET), to coordinate continuing education, training, and technical assistance for Wisconsin Family Planning programs and their community service partners. HCET will be coordinating the Wisconsin Family Planning program Education and Training Project. The purpose of the project is to improve and maintain the quality and cost effectiveness of family planning and related reproductive health services through community-based family planning programs. HCET will implement a Family Planning and Related Reproductive Health Care Standard of Practice Inventory of all certified providers. The inventory tool that will be utilized includes nine areas of concern:

   - Assessment and Surveillance
   - Delivery of Services
   - Record Keeping
   - Information, Education, and Outreach
   - Coordination
   - Referral Network
   - Provision of Guidance
   - Financial Management Practices
   - Data Collection, Analysis, and Reporting

   The inventory process checks to monitor whether: 1) Agency/Program Practices in Compliance with Requirements; 2) Policies and Protocols Address Requirements; and 3) Quality Assurance Systems to Monitor and Ensure Compliance. (See attached: "Title V/GPR Family Planning and Related Reproductive Health Care (including EIDP) Standard of Practice Inventory.")

   Additionally, the Title X training program has quality assurance and training of standards of care as top priority training topics, to ensure quality contraceptive care for all patients receiving services under the waiver.

2. **Who or which department will be responsible for monitoring quality assurance activities in the State?**

   The Division of Public Health will monitor the quality assurance activities conducted by HCET and Title X.

3. **Please be aware that HCFA approves Family Planning Demonstration for a period of 5 years. Upon approval a phase-out plan will be required as part of the terms and conditions for this demonstration.**

Budget Neutrality Worksheet for Wisconsin Proposal SFY 2001-2005

costs		1999	2000	2001	2002	2003	2004	2005	Total
WITHOUT WAIVER									
BASIC FP SERVS -- AN current eligibles	Persons	47000	47000	47000	47000	47000	47000	47000	
	PerCapita	$ -	$ -	$ -	$ -	$ -	$ -	$	
	Total	$ -	$ -	$ -	$ -	$ -	$ -	$	
DELIVERIES	Persons	6627	6627	6627	6627	6627	6627	6627	
	Per Capita	$ 1,978 00	$ 2,037 34	$ 2,098 46	$ 2,161 41	$ 2,226 25	$ 2,293 04	$ 2,361 83	
	Total	$ 13,108,206	$ 13,501,452	$ 13,906,494	$ 14,323,664	$ 14,753,359	$ 15,195,976	$ 15,651,847	$ 73,831,341
FIRST YEAR COSTS	Persons	6627	6627	6627	6627	6627	6627	6627	
	Per Capita	$ 989.00	$ 1,018.67	$ 1,049.23	$ 1,080.71	$ 1,113.13	$ 1,146 52	$ 1,180 92	
	Total	$ 6,554,103	$ 6,750,726	$ 6,953,247	$ 7,161,865	$ 7,376,713	$ 7,597,988	$ 7,825,957	$ 36,915,770
OTHER CHILD COSTS	Persons				6627	13254	19881	26508	
	PerCapita	$ 718	$ 739.54	$ 761.73	$ 784.58	$ 808.12	$ 832.36	$ 857.33	
	Total	$ -	$ -	$ -	$ 5,199,412	$ 10,710,822	$ 16,548,149	$ 22,726,104	$ 55,184,487
TOTAL BASE YEAR		$ 19,662,309	$ 20,252,178	$ 20,859,742	$ 26,684,941	$ 32,840,894	$ 39,342,113	$ 46,203,908	$ 165,931,597
WITH WAIVER									
BASIC FP SERVS	Persons	47000	47000	47000	47000	47000	47000	47000	
	Per Capita	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
	Total	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
'VERIES	Persons	6627	6627	6251	5619	4688	3457	1927	
	Per Capita	$ 1,978.00	$ 2,037.34	$ 2,098.46	$ 2,161.41	$ 2,226.25	$ 2,293.04	$ 2,361.83	
	Total	$ 13,108,206	$ 13,501,452	$ 13,117,473	$ 12,144,963	$ 10,436,660	$ 7,927,039	$ 4,551,246	$ 48,177,382
FIRST YEAR COSTS	Persons	6627	6627	6251	5619	4688	3457	1927	
	Per Capita	$ 989.00	$ 1,018.67	$ 1,049.23	$ 1,080.71	$ 1,113.13	$ 1,146.52	$ 1,180.92	
	Total	$ 6,554,103	$ 6,750,726	$ 6,558,737	$ 6,072,509	$ 5,218,353	$ 3,963,520	$ 2,275,633	$ 24,088,752
OTHER CHILD COSTS	Persons				6251	11870	16558	20015	
	Percapita	$ 718	$ 739.54	$ 761.73	$ 784.58	$ 808 12	$ 83236	$ 857.33	
EXPANDED FP	Persons	$ - 0	$ - 0	$ 11750	$ 4,902,0563	$ 9,592,8189	$ 13,782,217	$ 17,159,460	$ 45,438,471
	Per Capita	$ 185.00	$ 190.55	$ 196.27	$ 202.16	$ 208.22			
EXPANDED FP	Persons	$ - 0	$ - 0	$ 2,306,1730	$ 4,152,0563	$ 7,951,7189	47000	470001	
	PerCapita	$ 185.00	$ 190.55	$ 196.27	$ 202.16	$ 208.22	$ 214.47	$ 220.90	
	Total	$	-	$ 2,306,173	$ 4,157,016	$ 7,951,714	$ 10,080,090	$ 10,382,300	$ 34,877,292
SYSTEMS CHANGES		0	0	$ 487,777	$ 512,979	$ 624,759	$ 732,251	$ 835,455	$ 3,193,221
PUBLIC AWARENESS		$ -	$ -	$ -	$ -	$ -	$ -	$	
*EVALUATION***		$ -	$ -	$ -	$ -	$ -	$ -	$	
TOTAL WITH WAIVER COSTS									
DIFFERENCE		$ -	$ -	$ (1,610,418)	$ (1,106,936)	$ (982,977)	$ 2,856,996	$ 10,999,814	$ 10,156,479

*$100,000 in TANF funds have been allocated for outreach and educatior.

**Evaluation of the demonstration project will be done internally within the Department of Health and Family Services, and will be paid for by the Department.

Patient Rights and Provider Responsibilities

Privacy and Confidentiality Issues for Family Planning and Reproductive Health Services

A Resource Guide for the Wisconsin Family Planning Program

Appendices

Wisconsin Administrative Code Chapter HFS 151 "Family Planning Fund Allocations"

Wisconsin Administrative Code Chapter HFS 145 "Control of Communicable Diseases"

1997 Wisconsin Act 231 (published May 13, 1998)

Guidelines for Management of Family Planning Patient Information Maintained in Computer Database Applications

DOH Instructions for Completing STD Case Reports

Child Abuse and Neglect Reporting Guidelines

Sample Response to Request for Records

Chapter HFS 151

FAMILY PLANNING FUND ALLOCATIONS

Note: Chapter HSS 100 was renumbered chapter HSS 151 under s. 13.93 (2m) (b) 1. and 2., Stats., Register, June, 1990, No. 414. Chapter HSS 151 was renumbered Chapter HFS 151 under s. 13.93 (2m) (b) 1., Stats., and corrections made under s. 13.93 (2m) (b) 6. and 7., Stats., Register, August, 1997, No. 500.

HFS 151.01 Purpose. This chapter establishes the mechanism for the allocation of family planning funds appropriated to the department of health and family services pursuant to section 927 (18) (kp), ch. 418, laws of 1977.

History: Cr. Register, May, 1979, No. 281, eff. 6–1–79.

HFS 151.02 Definitions. (1) "Family planning" means family planning as defined in s. 146.80, Stats., and excludes specifically the voluntary termination of pregnancy and the provision of sterilization procedures to persons who are under the age of 21, incompetent or institutionalized.

(2) "Family planning services" means family planning services as defined in s. 146.80, Stats.

(3) "Coordination of family planning services" means the provision of family planning services in a manner that ensures the maximum use of existing community health, social service or welfare resources and local contractual arrangements.

History: Cr. Register, May, 1979, No. 281, eff. 6–1–79.

HFS 151.03 Grant procedures. (1) Family planning funds shall be allocated through a competitive grant award process. The department will establish procedures for the submission of grant applications and the awarding of grant funds.

(2) All grant applications shall, as a minimum, make the following assurances to the department:

(a) That the proposal maximizes the coordination of family planning services;

(b) That no persons employed by a grant applicant may be required to accept the duty of offering family planning services if that duty is contrary to his or her personal beliefs;

(c) That no person will be required by the grant applicant to accept family planning services or to state his/her reasons for rejecting such services and that such person's right to public assistance, public health, or other public service will be unaffected by their decision;

(d) That all information gathered by the grant applicant as a part of providing family planning services, other than statistical information compiled without reference to the identity of any individual, shall be released only with the informed consent of the individual for whom services have been provided.

History: Cr. Register, May, 1979, No. 281, eff. 6–1–79.

HFS 151.04 Records and reports. Agencies or individuals awarded funds pursuant to this chapter shall submit to the department such reports on number of clients served, services provided and expenditure of funds, as the department may require.

History: Cr. Register, May, 1979, No. 281, eff. 6–1–79.

Chapter HFS 145

CONTROL OF COMMUNICABLE DISEASES

Note: Chapter HSS 145 was renumbered chapter HFS 145 under s. 13.93 (2m) (b) 1., Stats., and corrections made under s. 13.93 (2m) (b) 6. and 7., Stats., Register, June, 1997, No. 498.

Subchapter I — General Provisions

HFS 145.01 Statutory authority. This chapter is promulgated under the authority of ss. 252.02 (4), 252.06 (1), 252.07 (4), 252.11 (1) and (1m), 252.21 (6) and 990.01 (5g), Stats.

History: Cr. Register, April, 1984, No. 340, eff. 5–1–84; corrections made under s. 13.93 (2m) (b) 7., Stats., Register, August, 1995, No. 476.

HFS 145.02 Purpose and scope. The chapter establishes a surveillance system for the purpose of controlling the incidence and spread of communicable diseases. This surveillance system consists of timely and effective communicable disease reporting, means of intervention to prevent transmission of communicable diseases, and investigation, prevention and control of outbreaks by local health officers and the department.

History: Cr. Register, April, 1984, No. 340, eff. 5–1–84.

HFS 145.03 Definitions. In this chapter:

(1) "Case" means a person determined to have a particular communicable disease on the basis of clinical or laboratory criteria or both.

(2) "Communicable disease" means a disease or condition listed in Appendix A of this chapter.

(3) "Date of onset" means the day on which the case or suspected case experienced the first sign or symptom of the communicable disease.

(4) "Department" means the department of health and family services.

(5) "Food handler" means a person who handles food utensils or who prepares, processes, or serves food or beverages for people other than members of his or her immediate household.

(6) "Health care facility" means a hospital, a nursing home, a home health agency, or a provider of outpatient health care.

(7) "Individual case report form" means the form provided by the department for the purpose of reporting communicable diseases.

(8) "Laboratory" means any facility certified by the department of agriculture, trade and consumer protection under ch. ATCP 77.

(9) "Local health officer" has the meaning prescribed in s. 250.01 (5), Stats., and applies to the person who is designated as the local health officer for the place of residence of a case or suspected case of communicable disease.

(10) "Organized program of infection control" means written policies and procedures for the purpose of surveillance, investigation, control and prevention of infections in a health care facility.

(11) "Other disease or condition having the potential to affect the health of other persons" means a disease that can be transmitted from one person to another but that is not reportable under this chapter and therefore is not listed in Appendix A of this chapter, although it is listed in *Control of Communicable Diseases in Man*, 14th edition (1985), edited by Abram S. Benenson, and published by the American Public Health Association.

(12) "Outbreak" means the occurrence in a particular area of communicable disease cases in excess of the expected number of cases.

(13) "Personal care" means the service provided by one person to another person who is not a member of his or her immediate household for the purpose of feeding, bathing, dressing, assisting with personal hygiene, changing diapers, changing bedding and other services involving direct physical contact.

(14) "State epidemiologist" means the person designated by the secretary of the department as the person in charge of communicable disease control for the state.

(15) "Suspected case" means a person thought to have a particular communicable disease on the basis of clinical or laboratory criteria or both.

Note: The handbook, *Control of Communicable Diseases in Man*, 14th edition (1985), edited by Abram S. Benenson, is on file in the department's bureau of public health, the revisor of statutes bureau, and the secretary of state's office, and is available for purchase from the American Public Health Association, 1015 Fifteenth St., NW, Washington, D.C., 20005.

History: Cr. Register, April, 1984, No. 340, eff. 5–1–84; am. (2) and (11), Register, February, 1989, No. 398, eff. 3–1–89; correction in (8) and (9) made under s. 13.93 (2m) (b) 7., Stats., Register, August, 1995, No. 476.

HFS 145.04 Reports of communicable diseases. **(1)** RESPONSIBILITY FOR REPORTING. (a) Any person licensed under ch. 441 or 448, Stats., knowing of or in attendance on a case or suspected case shall notify the local health officer or, if required under Appendix A of this chapter, the state epidemiologist, in the manner prescribed in this section.

(b) Each laboratory shall report the identification or suspected identification of a disease–causing organism or laboratory findings indicating the presence of a communicable disease to the local health officer or, if required under Appendix A of this chapter, to the state epidemiologist.

(c) Each health care facility shall ensure that reports are made to the local health officer or, if required under Appendix A of this chapter, to the state epidemiologist, in the manner specified in sub. (3). When a case is identified or suspected in a health care facility having an organized program of infection control, the person in charge of the infection control program shall ensure that the case or suspected case is reported to the local health officer or, if required under Appendix A of this chapter, to the state epidemiologist, minimizing unnecessary duplication.

(d) Any teacher, principal or nurse serving a school or day care center knowing of a case or suspected case in the school or center

delivery. No more than one newborn child may be treated from an individual container.

Note: The handbook, *Control of Communicable Diseases in Man*, 14th edition (1985), edited by Abram S. Benenson, is on file in the department's bureau of public health, the revisor of statutes bureau, and the secretary of state's office, and is available for purchase from the American Public Health Association, 1015 Fifteenth St., NW, Washington, D.C., 20005.

History: Cr. Register, April, 1984, No. 340, eff. 5–1–84; r. and recr. (4), Register, November, 1984, No. 347, eff. 12–1–84; am. (1) to (3), Register, February, 1989, No. 398, eff. 3–1–89.

Subchapter II — Tuberculosis

HFS 145.08 Definitions. In this subchapter:

(1) "Commitment" means the process by which a court of record orders the confinement of a person with infectious tuberculosis to a place providing care and isolation.

(2) "Contact" means any individual sharing a closed air environment with an infectious patient for an adequate period of time to allow the probability of infection to occur.

Note: This type of exposure usually includes household members and work or social associates.

(3) "Infectious tuberculosis" means tuberculosis disease of the respiratory tract capable of producing infection or disease in others, as demonstrated by the presence of acid–fast bacilli in the sputum or bronchial secretions, or by roentgenographic and clinical findings.

(4) "Isolation" means the separation of persons with infectious tuberculosis from other persons, in a place and under conditions that will prevent transmission of the infection.

(5) "Noninfectious" means the inability to produce infection or disease in others as demonstrated by asymptomatic status and either adequate chemotherapy having been initiated or absence of acid–fast bacilli in the sputum or bronchial secretions.

(6) "Public health dispensary" means a facility that meets the criteria of s. 252.10, Stats.

History: Cr. Register, April, 1984, No. 340, eff. 5–1–84.

HFS 145.09 Restriction of patients and contacts. **(1)** All individuals with infectious tuberculosis or suspected of having infectious tuberculosis, and their contacts, shall exercise all reasonable precautions to prevent the infection of others with whom they may come in contact, in accord with the methods of control for tuberculosis contained in *Control of Communicable Diseases in Man*, 14th edition (1985), edited by Abram S. Benenson, published by the American Public Health Association, unless specified otherwise by the state epidemiologist.

(2) No person with infectious tuberculosis or reasonably believed to be suffering from that disease may be permitted to attend any public gathering, including but not limited to school, nursery school or day care center, or return to work, until noninfectious.

(3) If an individual with infectious tuberculosis terminates treatment against medical advice, is noncompliant with the treatment plan, or leaves a hospital against the advice of a physician, the individual shall be reported to the local health officer and the department and may be isolated or committed as provided in sub. (4), if the local health officer or the department decides that isolation is necessary in order to protect others from becoming infected.

(4) Any individual with infectious tuberculosis, diagnosed by a physician, may be isolated or committed for care by the local health officer or by the department.

(5) If the administrative officer, where the person is isolated or committed, has good cause to believe that the person may leave without a court order, the officer may use any legal means to restrain the person from leaving. The administrative officer may segregate any person who is committed.

(6) The local health officer or delegated individual shall visit all individuals isolated or committed for tuberculosis at least once every 7 days to ascertain that the isolation or commitment is being maintained.

Note: The handbook, *Control of Communicable Diseases in Man*, 14th edition (1985), edited by Abram S. Benenson, is on file in the department's bureau of public health, the revisor of statutes bureau, and the secretary of state's office, and is available for purchase from the American Public Health Association, 1015 Fifteenth St., NW, Washington, D.C. 20005.

History: Cr. Register, April, 1984, No. 340, eff. 5–1–84; am. (1), Register, February, 1989, No. 398, eff. 3–1–89.

HFS 145.10 Discharge from isolation or commitment. The local health officer or the department shall authorize the release of an individual from isolation or shall petition a court to order the release of an individual from commitment if:

(1) An adequate course of chemotherapy has been initiated;

(2) Sputum or bronchial secretions are free of acid–fast bacilli or the number of acid–fast bacilli present is declining;

(3) Specific arrangements have been made for post–isolation or post–commitment care; and

(4) The person is considered by the local health officer or the department not to be a threat to the health of the general public.

History: Cr. Register, April, 1984, No. 340, eff. 5–1–84.

HFS 145.11 Limitations of care in public health dispensaries. **(1)** Newly diagnosed patients with tuberculosis disease may be approved for public health dispensary care for one year following the completion of chemotherapy.

(2) Infected patients receiving tuberculosis preventive treatment shall be discharged after completion of appropriate chemoprophylactic therapy.

History: Cr. Register, April, 1984, No. 340, eff. 5–1–84.

Subchapter III — Sexually Transmitted Disease

HFS 145.12 Definitions. In this subchapter:

(1) "Commitment" means the process by which a court of record orders the confinement of a person to a place providing care.

(2) "Contact" means a person who had sexual intercourse with a case during a period of time which covers both the maximum incubation period for the disease and the time during which the case showed symptoms of the disease, or could have either infected the case or been infected by the case.

(3) "Sexually transmitted diseases" mean syphilis, gonorrhea, chancroid, granuloma inguinale, lymphogranuloma venereum, genital herpes infection (first clinical episode only), nongonococcal urethritis, chlamydia trachomatis, other nongonococcal cervicitis, and sexually transmitted pelvic inflammatory disease.

(4) "Source" means the person epidemiologic evidence indicates to be the origin of infection.

(5) "Suspect" means a person who meets the criteria in s. HFS 145.16.

History: Cr. Register, April, 1984, No. 340, eff. 5–1–84.

HFS 145.13 Case reporting. Any administrator of a health care institution, state correctional institution or local facility subject to ch. DOC 350, who has knowledge of a case of a sexually transmitted disease shall report the case by name and address to the local health officer. Where the services of an attending physician are available in an institution, the physician shall report as described in s. HFS 145.04 (1) (a). The administrator shall ensure that this reporting requirement is fulfilled.

History: Cr. Register, April, 1984, No. 340, eff. 5–1–84; correction made under s. 13.93 (2m) (b) 7., Stats., Register, October, 1991, No. 430.

HFS 145.14 Reporting of cases delinquent in treatment. Whenever any person with a sexually transmitted disease fails to return to the physician who has treated that person within the time directed, the physician shall report the person, by name and address, to the local health officer and the department, as delinquent in treatment.

History: Cr. Register, April, 1984, No. 340, eff. 5–1–84.

State of Wisconsin

1997 Senate Bill 315

Date of enactment: April 30, 1998
Date of publication*: May 13, 1998

1997 WISCONSIN ACT 231

(Vetoed in Part)

AN ACT *to repeal* 153.01 (3) and (9), 153.05 (1) (a) to (e), 153.05 (2), 153.05 (4), 153.05 (5) (a) and (bm), 153.05 (7), 153.05 (11), 153.07 (2), 153.08 (2) (b), 153.10 (1) (a) and (b), 153.10 (2), 153.15, 153.25, 153.30, 153.35, 153.40, 153.60 (2) 153.75 (1) (c), (d), (e), (i) and (j) and 153.75 (2) (b); *to renumber and amend* 153.05 (1) (intro.) and 153.10 (1) (intro.); *to consolidate, renumber and amend* 153.05 (5) (intro.) and (b) and 153.08 (2) (intro.) and (a); *to amend* 15.195 (6), 16.03 (1), 20.435 (1) (hg), 51.30 (4) (a). 146.82 (2) (b), 153.05 (3), 153.05 (6). 153.05 (6m), 153.05 (8), 153.05 (9), 153.07 (1), 153.20, 153.45 (1) (intro.), 153.45 (1) (a), 153.45 (1) (b), 153.45 (1) (c). 153.45 (3). 153.60 (1), 153.65, 153.75 (1) (b), 153.75 (1) (f), (k) and (L), 153.75 (2) (intro.) and 153.90 (1) and (2); *and recreate* 153.50; and *to create* [redacted] 15.107 (7) (g), [redacted] 153.01 (4d), (4h), (4p) and (4t), 153.05 (6r), 153.05 (13), 153.07 (4). 153.07 (5), 153.21, 153.45 (1m), 153.45 (4). 153.45 (5), 153.55, 153.60 (3). 153.75 (1) (m), (n), (o), (p), (q), (r), (s), (t) and (u), 153.75 (2) (d), 227.01 (13) (yt), 440.03 (11m), 610.70 [redacted] and 943.30 (5) of the statutes; **relating to: collection, analysis** and **dissemination of health care information by the department of health and family services, confidentiality of patient health care records, health care provider confidentiality, storage and disposal requirements containing medical and financial information, membership of the board on health care information, authorizing disclosure of personal medical information to an insurer, disclosure by an insurer of personal medical information, granting rule-making authority, providing a penalty and making appropriations.** Vetoed In Part

The people of the state of [redacted] *represented in* [redacted] *enact as follows:*

Vetoed In Part [redacted]

SECTION 2. 15.107 (7) (g) of the statutes is created to read:

15.107 (7) (g) A representative of the office of the commissioner of insurance.

Vetoed In Part [redacted]

[redacted] Vetoed In Part

SECTION 4. 15.195 (6) of the statutes, as affected by 1997 Wisconsin Act 27, is amended to read:

15.195 (6) BOARD ON HEALTH CARE INFORMATION. There is created a board on health care information which is attached to the department of health and family services under s. 15.03. The board shall consist of 9 11 members, ~~a majority of whom may neither be nor~~ one of whom shall be a record administrator, registered by the American Medical Record Association, and 5 of whom shall be or represent health care providers, including one registered nurse, licensed under s. 441.06, and [redacted] physicians, as defined in s. 448.01 (5). The State Medical Society of Wisconsin may recommend board member-

* Section 991.11, WISCONSIN STATUTES 1995–96: Effective date of acts. "Every act and every portion of an act enacted by the legislature over the governor's partial veto which does not expressly prescribe the time when it takes effect shall take effect on the day after its date of publication as designated" by the secretary of state [the date of publication may not be more than 10 working days after the date of enactment].

~~quired of the department~~ in the form specified by the department by rule.

SECTION 17. 153.05 (5) (a) and (bm) of the statutes, as affected by 1997 Wisconsin Act 27, are repealed.

SECTION 18. 153.05 (6) of the statutes, as affected by 1997 Wisconsin Act 27, is amended to read:

153.05 (6) ~~If the requirements of s. 153.07 (2) are first met, the~~ The department may contract with a public or private entity that is not a major purchaser, payer or provider of health care services in this state for the provision of data processing services for the collection, analysis and dissemination of health care information under sub. (1) ~~or the department shall provide the services under s. 153.07 (2)~~.

SECTION 19. 153.05 (6m) of the statutes, as affected by 1997 Wisconsin Act 27, is amended to read:

153.05 (6m) ~~If the requirements of s. 153.07 (2) are first met, the~~ The department may contract with the group insurance board for the provision of data collection and analysis services related to health maintenance organizations and insurance companies that provide health insurance for state employes ~~or the department shall provide the services under s. 153.07 (2)~~. The department shall establish contract fees for the provision of the services. All moneys collected under this subsection shall be credited to the appropriation under s. 20.435 (1) ~~(ex)~~ (hg).

SECTION 20. 153.05 (6r) of the statutes is created to read:

153.05 (6r) The department shall study and, based on the results of the study, may develop and implement a voluntary system of health care plan reporting that enables purchasers and consumers to assess the performance of health care plans and the health care providers that are employed or reimbursed by the health care plans. The department shall undertake the study and any development and implementation in cooperation with private health care purchasers, the board, the department of employe trust funds, the office of the commissioner of insurance, the interagency coordinating council created under s. 15.107 (7), major associations of health care providers, health care plans and consumers. If implemented, the department shall operate the system in a manner so as to enable purchasers, consumers, the public, the governor and legislators to assess the performance of health care plans and health care providers.

SECTION 21. 153.05 (7) of the statutes, as affected by 1997 Wisconsin Act, is repealed.

SECTION 22. 153.05 (8) of the statutes, as affected by 1997 Wisconsin Act 27, is amended to read:

153.05 (8) ~~Beginning April 1, 1992, the~~ Unless sub. (13) applies, the department shall collect, analyze and disseminate, in language that is understandable to lay persons, ~~health care~~ claims information and other health care information, as adjusted for case mix and severity, under the provisions of this chapter, as determined by rules promulgated by the department, from health care providers, ~~as defined~~ specified by rules promulgated by the department, ~~other than hospitals and ambulatory surgery centers~~. Data from ~~physicians shall~~ health care providers may be obtained through sampling techniques in lieu of collection of data on all patient encounters and data collection procedures shall minimize unnecessary duplication and administrative burdens. If the department collects health care provider–specific data from health care plans, the department shall attempt to avoid collecting the same data from health care providers. The [redacted] **Vetoed In Part**

[redacted]

SECTION 23. 153.05 (9) of the statutes, as affected by 1997 Wisconsin Act 27, is amended to read:

153.05 (9) The department shall provide orientation and training to ~~physicians, hospital personnel and other~~ health care providers who submit data under this chapter to explain the process of data collection and analysis and the procedures for data verification, comment, interpretation and release.

SECTION 24. 153.05 (11) of the statutes, as affected by 1997 Wisconsin Act 27, is repealed.

SECTION 25. 153.05 (13) of the statutes is created to read:

153.05 (13) The department may waive the requirement under sub. (1), (5) or (8) for a health care provider, who requests the waiver and presents evidence to the department that the requirement under sub. (1), (5) or (8) is burdensome, under standards established by the department by rule. The department shall develop a form for use by a health care provider in submitting a request under this subsection.

SECTION 26. 153.07 (1) of the statutes, as affected by 1997 Wisconsin Act 27, is amended to read:

153.07 (1) The board shall advise ~~the director of the~~ department with regard to the collection, analysis and dissemination of health care information required by this chapter.

SECTION 27. 153.07 (2) of the statutes, as affected by 1997 Wisconsin Act 27, is repealed.

SECTION 28. 153.07 (4) of the statutes is created to read:

153.07 (4) The board and the department shall jointly do all of the following:

[redacted] **Vetoed In Part**

(b) Provide oversight on the standard reports under this chapter, including the reports under ss. 153.20 and 153.21.

(c) Develop the overall strategy and direction for implementation of this chapter.

153.45 **(1m) After completion of data verification and review procedures specified** by the department by rule, **the department may,** but is not required **to,** release **special data compilations.**

rules

(3) DEPARTMENTAL MEASURES TO ENSURE PROTECTION OF PATIENT IDENTITY. To ensure that the identity of patients is protected when information obtained by the department is disseminated, the department shall do all of the following:

(a) Aggregate any data element category containing small numbers, using procedures that are developed by the department and approved by the board and that follow commonly accepted statistical methodology.

(b) Remove and destroy all of the following data elements on the uniform patient billing forms that are received by the department under the requirements of this chapter:

1. The patient's name and street address.

2. The insured's name, address and telephone number.

3. Any other insured's name, employer name and date of birth.

4. The signature of the patient or other authorized signature.

5. The signature of the insured or other authorized signature.

6. The signature of the physician.

(4) RELEASE OF PATIENT–IDENTIFIABLE DATA. Under the procedures specified in sub. (5), release of patient–identifiable data may be made to any of the following:

(a) The patient or a person granted permission in writing by the patient for release of the patient's patient–identifiable data.

(b) An agent of the department who is responsible for the patient–identifiable data in the department, in order to store the data and ensure the accuracy of the information in the data base of the department.

(c) A health care provider or the agent of a health care provider, to ensure the accuracy of the information in the data base of the department.

(d) The department, for purposes of epidemiological investigation or to eliminate the need for duplicative data bases.

(e) An entity that is required by federal or state statute to obtain patient–identifiable data for purposes of epidemiological investigation or to eliminate the need for duplicative data bases.

(5) PROCEDURES FOR RELEASE OF PATIENT–IDENTIFIABLE DATA. (a) The department may not release or provide access to patient–identifiable data to a person authorized under sub. (4) (a), (c), (d) or (e) unless the authorized person requests the department, in writing, to release the patient–identifiable data. The request shall include all of the following:

1. The requester's name and address.

2. The reason for the request.

3. For a person who is authorized under sub. (4) (a), (c) or (d) to receive or have access to patient–identifiable

(k) Establishing methods and criteria for assessing ~~hospitals and ambulatory surgery centers~~ health care providers under s. 153.60 (1).

(L) Defining the term "uncompensated health care services" for the purposes of ~~ss. 153.05 (1) (d) and~~ s. 153.20.

SECTION 56. 153.75 (1) (m), (n), (o), (p), (q), (r), (s), (t) and (u) of the statutes are created to read:

153.75 (1) (m) Specifying the classes of health care providers from whom claims data and other health care information will be collected.

(n) Specifying the uniform data set of health care information, as adjusted for case mix and severity, to be collected.

(o) Specifying the means by which the information in par. (b) will be collected, including the procedures for submission of data by electronic means.

(p) Specifying the methods for using and disseminating health care data in order for health care providers to provide health care that is effective and economically efficient and for consumers and purchasers to make informed decisions in selecting health care plans and health care providers.

(q) Specifying the information to be provided in the consumer guide under s. 153.21.

(r) Specifying the standard reports that will be issued by the department in addition to those required in ss. 153.20 and 153.21.

(s) Defining "individual data elements" for purposes of s. 153.45 (4).

(t) Establishing standards for determining under s. 153.05 (1) if a requirement under s. 153.05 (1), (5) or (8) is burdensome for a health care provider.

(u) Specifying the methods for adjusting health care information for case mix and severity.

SECTION 57. 153.75 (2) (intro.) of the statutes, as affected by 1997 Wisconsin Act 27, is amended to read:

153.75 (2) (intro.) ~~With the~~ Following approval of by the board, the department may promulgate all of the following rules:

SECTION 58. 153.75 (2) (b) of the statutes is repealed.

SECTION 59. 153.75 (2) (d) of the statutes is created to read:

153.75 (2) (d) Specifying the information collected under any voluntary system of health care plan reporting under s. 153.05 (6r) and the methods and criteria for assessing health care plans that submit data under that subsection.

SECTION 60. 153.90 (1) and (2) of the statutes are amended to read:

153.90 (1) Whoever intentionally violates s. 153.45 (5) or 153.50 or rules promulgated under s. 153.75 (1) (a) may be fined not more than $10,000 or imprisoned for not more than 9 months or both.

(2) Any person who violates this chapter or any rule promulgated under the authority of this chapter, except ss. 153.45 (5), 153.50 and 153.75 (1) (a), as provided in s. 153.85 and sub. (1), shall forfeit not more than $100 for each violation. Each day of violation constitutes a separate offense, except that no day in the period between the date on which a request for a hearing is filed under s. 227.44 and the date of the conclusion of all administrative and judicial proceedings arising out of a decision under this section constitutes a violation.

SECTION 60g. 227.01 (13) (yt) of the statutes is created to read:

227.01 (13) (yt) Relates to the amounts of assessments that are made under s. 153.60 (1) for health care providers.

SECTION 60r. 440.03 (11m) of the statutes is created to read:

440.03 (11m) The department shall work together with the department of health and family services to develop a mechanism for collecting assessments under s. 153.60 (1) from health care providers other than hospitals and ambulatory surgery centers.

SECTION 61. 610.70 of the statutes is created to read:

610.70 Disclosure of personal medical information. (1) DEFINITIONS. In this section:

(a) "Health care provider" means any person licensed, registered, permitted or certified by the department of health and family services or the department of regulation and licensing to provide health care services, items or supplies in this state.

(b) "Individual" means a natural person who is a resident of this state. For purposes of this paragraph, a person is a state resident if his or her last–known mailing address, according to the records of an insurer or insurance support organization, was in this state.

(c) 1. "Insurance support organization" means any person that regularly engages in assembling or collecting personal medical information about natural persons for the primary purpose of providing the personal medical information to insurers for insurance transactions, including the collection of personal medical information from insurers and other insurance support organizations for the purpose of detecting or preventing fraud, material misrepresentation or material nondisclosure in connection with insurance underwriting or insurance claim activity.

2. Notwithstanding subd. 1., "insurance support organization" does not include insurance agents, government institutions, insurers or health care providers.

(d) "Insurance transaction" means any of the following involving insurance that is primarily for personal, family or household needs:

1. The determination of an individual's eligibility for an insurance coverage, benefit or payment.

2. The servicing of an insurance application, policy, contract or certificate.

(e) "Medical care institution" means a facility, as defined in s. 647.01 (4), or any hospital, nursing home,

is the subject of the request and if the information is reasonably easy to locate and retrieve by the insurer.

(d) If an insurer receives personal medical information from a health care provider or a medical care institution with instructions restricting disclosure of the information under s. 51.30 (4) (d) 1. to the individual to whom the information relates, the insurer may not disclose the personal medical information to the individual under this subsection, but shall disclose to the individual the identity of the health care provider or a medical care institution that provided the information.

(e) Any copy of recorded personal medical information provided under par. (a) or (b) shall include the identity of the source of the information if the source is a health care provider or a medical care institution.

(f) An insurer may charge the individual a reasonable fee to cover the costs incurred in providing a copy of recorded personal medical information under par. (a) or (b).

(g) The requirements for an insurer under this subsection may be satisfied by another insurer, an insurance agent, an insurance support organization or any other entity authorized by the insurer to act on its behalf.

(h) The requirements under this subsection do not apply to information concerning an individual that relates to, and that is collected in connection with or in reasonable anticipation of, a claim or civil or criminal proceeding involving the individual.

(4) CORRECTION, AMENDMENT OR DELETION OF RECORDED PERSONAL MEDICAL INFORMATION. (a) Within 30 business days after receiving a written request from an individual to correct, amend or delete any recorded personal medical information that is in the insurer's possession, an insurer shall do either of the following:

1. Comply with the request.

2. Notify the individual of all of the following:

a. That the insurer refuses to comply with the request.

b. The reasons for the refusal.

c. That the individual has a right to file a statement as provided in par. (c).

(b) An insurer that complies with a request under par. (a) shall notify the individual of that compliance in writing and furnish the correction, amendment or fact of deletion to all of the following:

1. Any person who may have received, within the preceding 2 years, the recorded personal medical information concerning the individual and who is specifically designated by the individual.

2. Any insurance support organization for which insurers are the primary source of personal medical information and to which the insurer, within the preceding 7 years, has systematically provided recorded personal medical information. This subdivision does not apply to an insurance support organization that does not maintain recorded personal medical information concerning the individual.

3. Any insurance support organization that furnished to the insurer the personal medical information that has been corrected, amended or deleted.

(c) If an insurer refuses to comply with a request under par. (a) 1., the individual making the request may file with the insurer, an insurance agent or an insurance support organization any of the following:

1. A concise statement setting forth the information that the individual believes to be correct, relevant or fair.

2. A concise statement setting forth the reasons why the individual disagrees with the insurer's refusal to correct, amend or delete the recorded personal medical information.

(d) If the individual files a statement under par. (c), the insurer shall do all of the following:

1. File any statement filed by the individual under par. (c) with the recorded personal medical information that is the subject of the request under par. (a) in such a manner that any person reviewing the recorded personal medical information will be aware of and have access to the statement.

2. In any subsequent disclosure by the insurer of the recorded personal medical information, clearly identify any matter in dispute and provide any statement filed by the individual under par. (c) that relates to the recorded personal medical information along with the information.

3. Furnish any statement filed by the individual under par. (c) to any person to whom the insurer would have been required to furnish a correction, amendment or fact of deletion under par. (b).

(e) The requirements under this subsection do not apply to information concerning an individual that relates to, and that is collected in connection with or in reasonable anticipation of, a claim or civil or criminal proceeding involving the individual.

(5) DISCLOSURE OF PERSONAL MEDICAL INFORMATION BY INSURERS. Any disclosure by an insurer of personal medical information concerning an individual shall be consistent with the individual's signed disclosure authorization form, unless the disclosure satisfies any of the following:

(a) Is otherwise authorized by the individual, or by a person who is authorized to consent on behalf of an individual who lacks the capacity to consent.

(b) Is reasonably related to the protection of the insurer's interests in the assessment of causation, fault or liability or in the detection or prevention of criminal activity, fraud, material misrepresentation or material nondisclosure.

(c) Is made to an insurance regulatory authority or in response to an administrative or judicial order, including a search warrant or subpoena, that is valid on its face.

(d) Is otherwise permitted by law.

act against the person's will or omit to do any lawful act, is guilty of a Class D felony.

SECTION 64. Nonstatutory provisions; administration.

(1) INTERAGENCY COORDINATING COUNCIL MEMBER. Notwithstanding the length of terms of members specified in section 15.107 (7) (intro.) of the statutes, the member appointed to the interagency coordinating council under section 15.107 (7) (g) of the statutes, as created by this act, shall serve for an initial term that expires on July 1, 2003.

SECTION 65. Nonstatutory provisions; health and family services.

(1) REPORT AND PLAN ON CHARITY CARE AND BAD DEBT SERVICES. The department of health and family services shall prepare a report on the feasibility of requiring major health care providers, other than hospitals, to report annually on the services provided as either charity care or bad debt services and to file an annual plan on projected services that will be provided as either charity care or bad debt services, in the same manner as the annual report and plan by hospitals under section 153.20 of the statutes, as affected by this act. By the first day of the 7th month after publication of this act, the department shall submit the report to the legislature in the manner provided under section 13.172 (2) of the statutes, to the board on health care information and to the governor.

(2) BOARD ON HEALTH CARE INFORMATION MEMBERS. Notwithstanding the length of terms specified for the members of the board on health care information under section 15.195 (6) of the statutes, as affected by this act, the 10th and 11th initial members appointed under that subsection shall be appointed for a term expiring on May 1, 2002.

(3) PLAN FOR CORRECTION OF ERRONEOUS DATA. The department of health and family services shall develop a plan for the correction of erroneous data collected under section 153.05 (1), (5) and (8) of the statutes, as affected by this act. The department of health and family services may not implement procedures under the plan unless the plan is approved by the board on health care information. The department of health and family services shall implement the procedures under the plan at the time data is first collected from health care providers under section 153.05 (1), (5) and (8) of the statutes, as affected by this act.

(3t) REPORT ON INFORMATION COLLECTED FROM A MEDICAL SCHOOL FACULTY MEMBER. The department of health and family services shall report on whether health care information that is collected under chapter 153 of the statutes, as affected by this act, from a physician who is a member of the faculty of a medical school should be adjusted to reflect services rendered by residents or fellows in medical education who are under the supervision of the physician. The department shall submit the report by July 1, 1999, to the legislature in the manner provided under section 13.172 (2) of the statutes, and to the governor.

SECTION 65m. Appropriation changes; health and family services.

(1) REPORT ON INFORMATION COLLECTED FROM A MEDICAL SCHOOL FACULTY MEMBER. In the schedule under section 20.005 (3) of the statutes for the appropriation to the department of health and family services under section 20.435 (6) (a) of the statutes, as affected by the acts of 1997, the dollar amount is increased by $5,200 for fiscal year 1998–99 to increase funding to contract with the Medical College of Wisconsin for the preparation of the report under SECTION 65 (3t) of this act. Vetoed In Part

SECTION 66. Initial applicability.

[redacted] Vetoed In Part

(2) DISCLOSURE BY INSURERS OF PERSONAL MEDICAL INFORMATION. If a contract that is affected by section 610.70 of the statutes, as created by this act, that is in effect on the first day of the 13th month beginning after publication and that was not issued or renewed after the effective date of this subsection contains terms or provisions that are inconsistent with the requirements under section 610.70 of the statutes, as created by this act, the treatment of sections 51.30 (4) (a), 146.82 (2) (b) and 610.70 of the statutes first applies to that contract upon renewal.

SECTION 67. Effective dates. This act takes effect on the day after publication, except as follows:

(1) The treatment of sections 51.30 (4) (a), 146.82 (2) (b) and 610.70 of the statutes takes effect on the first day of the 13th month beginning after publication.

[redacted] Vetoed In Part

Guidelines for Management of Family Planning Patient Information Maintained in Computer Database Applications

Introduction

The purpose of this paper, an appendix to *Patient Rights and Provider Responsibilities: Privacy and Confidentiality Issues for Family Planning and Reproductive Health Services*, is to provide guidance to health care providers and agencies to ensure protection of patient privacy and confidentiality rights. It contains guidelines for the management of family planning and related reproductive health patient information maintained in computer database files and records. Two main issues are addressed:

First, the legal-ethical *context* for maintaining family planning and related reproductive health patient information in computer database files and records.

Second, guidelines for the development and use of computer database applications, and development of information management policies to ensure providers meet their responsibilities for protecting the privacy and confidentiality rights of family planning patients.

Family planning projects, clinics, and providers have an obligation to protect and secure patient information from loss, alteration, unauthorized access, or un-consented disclosure (except as required by law). Information management involves establishing boundaries around patient information beyond which patient consent is required for access by or disclosure to other persons or agencies (except as required by law). Because family planning and related reproductive health patient information have more stringent privacy and confidentiality requirements than other less sensitive health care information, establishing clear boundaries is more important.

Sharing computer-based health care information across programs has emerged in the field of public health in recent years. Attachment A illustrates the evolution of 'integrated data systems'. Differentiating between family planning and related reproductive health information, and other less sensitive and protected patient information, and formally establishing clear limitations on access to information becomes more important in this *context.*

Unauthorized access to or un-consented disclosure of sensitive information can have harmful consequences to patients, and negative impact on the effectiveness of programs providing these services. Within family planning programs, access to patient information is limited to personnel with formally delegated responsibility to provide *family* planning core services (or to family planning supervisory personnel) who are subject to formal disciplinary action for breech of confidentiality and privacy policies. Penalties for unauthorized access to computer-based information are defined in Wisconsin statutes at s. 943.70(2). (See Attachment C).

Protecting and safeguarding patient information stored in electronic format (in computer database files and records) is more complicated than protection of paper-based information. Access to information stored in database files and records *can* be accessed in more ways, directly or indirectly, and *can* be copied and disseminated more quickly than paper-based records. The higher the risk of unauthorized access or un-consented disclosure, the greater the responsibilities of family planning projects, clinics, and providers to protect patient computer-based information.

This paper is divided into the following sections:

Overview of Database Applications

Family planning projects, clinics, and providers have an obligation to protect and secure patient information from loss, alteration, unauthorized access, or un-consented disclosure (except as required by law). Guidelines for security of computer-based patient information should parallel guidelines for paper-based records. Protection of paper-based records in family planning programs include: • records/patient charts that contain only family planning patient information; • storage of records, patient *charts,* and patient information in locked file cabinets; • storage of file cabinets in locked rooms; • access limited to personnel with formally delegated responsibility far provision of family planning services.

Storage and security of computer-based patient records differ from paper-based records in two key ways. First, patient information maintained in computer database files are located either *on* a directory of a personal computer *or* on a subdirectory of a Local Area Network Second, access to *these* files is accomplished in *either* of two ways: 1) through the database application software (data entry *screens* or data analysis/report commands), or 2) by directly accessing the files created by the database application software. These differences from paper-based records shape the guidelines presented in the next section.

Database applications have different purposes, capabilities, and uses. First, database applications vary from those used exclusively for family planning patient Information to ones used in multiple programs (within or outside an agency). Second, database applications vary *from* applications designed as *stand-alone* programs to those designed to transfer information across files, and to those designed to share information stored in common files. Third, database applications also vary *from* those used *on* a stand-alone computer *to* those used in a network environment Fourth, database applications further vary from those used to measure performance and quality indicators/outcomes to those used primarily for patient tracking, surveillance, or clinic management. The greater the extent to which database files/records are inter-related or identical database applications are used in different programs, the greater the potential for unauthorized access to and un-consented disclosure of patient information. Penalties for unauthorized access to computer-based information are defined at Wisconsin statutes s. 943.70(2). (See Attachment C). Guidelines for each database application below are outlined in the next section.

Database Application Designs

A. Database applications designed to exclusively contain family planning/reproductive health patient information: *stand-alone* applications with no capability for merging, matching, or linking files/records with other (non-family planning) files/records; files containing family planning patient records are *segregated* from *other* patient files/records. (Page 4).

B. Database applications designed with the capability to transfer patient information between family planning records and other records. These applications transfer patient information from other program only: importing patient data *from other agency* databases *into* family planning patient database(s). An important distinction is made between release (or transfer) of patient information from files/records in one database to files/records in a separate database (designs B and C) versus 'open access" database applications (Design D) that share common files/records. (Page 5). (See Definitions).

C. Database applications designed with the capability to transfer patient information between family planning records and other records. These applications transfer family planning program patient information to *other* programs only: exporting patient i——— from family planning database files/records to other program database files/records. Database designs B and C have no shared *or* linked files with *other* patient health care databases. (Page 5).

D. Database applications designed with the capability to share common patient information between (to/from) family planning database files/records and other database files/records. This design has files/records shared in common *or* linked with databases for other patient health care programs, projects, *or* services. (page 6).

E. Database applications designed with *the* capability for client tracking or for integrated data. Client tracking applications maintain composite information for each client served within an *agency (or* among different agencies) including service providers, service history, personal health *care* needs, family health care needs, etc. This design has files/records *shared* in common or linked with other program databases (within *or outside* an agency). Integrated data involves the capability to merge, match, or link client files/records in different databases *across* multiple programs, projects, or services within an agency *(or* in different agencies) for surveillance, client tracking, or other data analysis. (Page 10).

B. Database applications designed with the capacity to only transfer patient information *from* other agency database files/records *into* family planning patient database files/records: applications with no other capability for merging, matching, or linking files/records with other (non-family planning) files/records; applications designed to segregate family planning patient information from *other* patient records. These database applications have no files/records *shared* in common with *or* linked to other program, project, or service database files/records. The diagram in Attachment D illustrates database designs B and C.

- § Patient information *can* be obtained from client databases maintained in *other* programs if family planning patients provide prior written informed consent for release (electronic transfer) of the information to the family planning program. Obtaining information without formal written informed *consent* would be inconsistent with family planning patient information management legal-ethical policies that patients should retain control over access to their information.

- § The development and use of this database application should conform to the guidelines under Database A (page 5).

C. Database applications designed with the capability to only transfer family planning program patient information *to* database files/records in other agency programs. projects, or services: applications with no *other* capability for merging, matching, or linking files/records with other (non-family planning) files/records; applications designed to segregate family planning patient information from other patient records. These database applications have no files/records shared in common with *or* linked to other program, project, *or* service database files/records.

- § Family planning patients must give prior written informed *consent* for inclusion of any information (that could either directly or indirectly reveal their identity) in a database to which agency *staff* beyond the immediate group of family planning providers have access. Access to family planning information in family planning programs is limited only to staff providing family planning services; other staff within a larger parent agency should not have access to patient information without prior, formal written informed consent.

- § All elements of proper and complete informed consent are required. Requirements for each release of information includes: • Consent for release of electronically stored information into an agency-wide database must be limited to a specific time period, and patients must be informed of their right to revoke *consent* at any time. • The consent must define a specific time period for inclusion of patient information as records in the Agency Client-Census files, after which, if *consent* is not renewed, the information will be removed. An indefinite time period with the burden upon patients to revoke consent is not acceptable. • An explanation is required that agency *staff* - beyond family planning *staff* - will have access to the information: that *other* agency staff would know that the patient had been seen within the agency but would be unable to determine for what specific services. • Patients must be informed of their right to request a list of *staff* who had accessed their records in the agency database, and the purpose of the access. • The consent must assure that information will not be accessible to *any* person *or* agency outside the specific agency maintaining the database.

- § The development and use of the database application should conform to the guidelines under database A; formal information management policies should be established to ensure data security.

status or service facts) could be released into the agency database on the basis of an approved informed *consent* document *assuming*: 1) use of the patient data as assumed', 2) development and use of *the* database application based upon guidelines under database A. with formal administrative policies, and 3) legal protection of Information maintained in the larger agency database from release without consent.

Information could include the following patient Information:

FIELDS	FIELDS	FIELDS
Client Name Agency Client Number	Agency Client Number Race/Ethnicity Zipcode/County Gender DOB	Family Planning Information
Agency Client File	Agency Census File*	CLIENT, VISIT, SERVICE, & PROBLEM FILES
AGENCY-WIDE DATABASE		FAMILY PLANNING PROGRAM DATABASE

*Assumptions on how agency-wide Client Census Filer would be used:
Data Entry: a search in the agency Client-Census ALES would occur before creating a *new* patient record in the family planning program file. if patient information is present in the Client-Census FILES, data could be imported into the family planning SCREENS rather than re-typed. If patient information is not present in the Client-Census FILES, patient information would be typed into the Family Planning SCREENS and saved in the Family Planning database. Assuming informed *consent* by the patient, client census information would be exported from the Family Planning SCREENS to a record in the agency Client-Census FILES.

Data Analysis: the agency Client-Census ALES would be used to determine the age, race, ethnicity, and zipcode distribution of patients served within the agency.

Tho following data would not be allowed in the Agency-wide database files (Client and Census Files):
- Family Planning Service information
- Health status information
- family size (minors are counted as 1: a flag for family planning services)
- Medicaid number
- Health care coverage (a flag for family planning services)
- Address
- Telephone number
- Family Code

These data increase the potential of unnecessary privacy/confidentially 'exposure', and provide opportunities for linking, matching, or merging records containing family planning patient information with non-family piannlng patlent records.

§ The development and use of the database application should *conform* to the guidelines under database A.; formal information management policies should be established to ensure data security.

§ Security of family planning patient information maintained In a computer database should be adequately ensured. Security consists of the technical design of the database application, and administrative policies defining patient privacy and confidentiality protection. The following database design and information management policies for family planning patient information are required for providers to fulfill their obligations for safeguarding family planning patient privacy and confidentiality rights:

Additional Considerations for Use of Integrated Database *Applications*

§ **Can complete and proper informed consent be given by family planning patients in the** context **of computer databases shared across multiple programs (or agencies)?** Informed consent *to* **release** information into data systems using common files/records for different programs may have **serious** practical and ethical limitations. Many clients might *not* fully understand the implications **and scope of** data sharing. Providers might not be able to provide accurate information *on* all potential access to or disclosures of the information. Patients who are the most dependent upon the **services** could **easily** perceive release as a requirement: voluntary *choice* **would not** realistically **exit** under **these circumstances.** A serious **question** remains regarding patient information shared across different **programs will** patients who are financially dependent upon receiving family planning **services** perceive a *voluntary choice* in consenting to **release of personal** Information into an agency-wide database?

§ **Can** the **increased potential of patient information exposure be justified when information is** not **directly related to patient care, such as with a direct referral? What are** the **benefits to the agency, and to the *patient.* What are the potential risks to the agency and to the patient? Information** maintained in a computer database, regardless of technical **safeguards, is** potentially more accessible to **individuals** to whom access is not authorized or intended. Maintaining patient information for administrative purposes is different than management of information for the purpose of facilitating specific **services, such as** release of a pregnant patient's name and other medical, laboratory, or history information (with consent) for a referral to the PNCC program for follow-up contact and enrollment.

Benefits to an agency **potentially** comes from avoiding unnecessary **data** entry for newly enrolled family planning patients previously seen in the agency, or by avoiding unnecessary data entry in *other* agency programs for **patients** previously enrolled in the family planning program. "Time saving" **justifications** need to account for time used for data look-up. Individual patients derive no direct individual benefit **from** an agency-wide database beyond traditional information management practices which have less information "exposure" potential.

increased liability for exposure of famiiy planning patient information **maintained** on an agency-wide **database** is a **potential** risk to agencies and providers. A strong argument can be made that **an** agency-wide **database** is **not** essential for providing services to the patient, **and** results in unnecessary information exposure for **individual** patients while providing only minimal administrative convenience. Potential risks to **individual** patients would include increased **risk** of information "exposure". Access to an individual's family planning patient's name in an agency-wide database might not provide reasonable anonymity throughout the agency for protection of confidentiality for minor patients.

Definitions

Agency Client-Census Database. Agency Database files consisting of records for individuals who are or have been CLIENTS within the agency, and containing demographic (CENSUS) information. To protect the privacy of individual patients, database files containing demographic information might contain only a unique client identifier (no name) that could be related to a database file containing client names and their unique client number.

Agency Client Identifier. A unique identifier (consisting of alpha and/or numeric characters) assigned to each individual client within the agency.

Client Tracking System. A data system that *tracks* the progress of a client for services provided and activities associated with a client's participation in various programs.

family Code. A unique identifier common to all members of the same family which permits records of individual famiiy members to be linked for data analysis of family unit Information.

Family Planning Patient Identifier. A unique identifier assigned to each individual family planning patient enrolled in the family planning program.

Family planning program (or project). The formally defined group or unit of family planning providers within an agency or organization.

Family planning providers. Personnel within an agency (or under *contract* with an agency) with formally delegated responsibility to provide family planning core services or specialized functions, such as billing, quality assurance, or information management, e.g., computer hardware/software consultants (or supervisory personnel of family planning personnel) who are subject to formal disciplinary action for breech of confidentiality and privacy policies.

Integrated Database. Combined client information maintained under a single system 'umbrella' (either a single comprehensive file or related files) including demographic information, *services* and activities related to the client, clinic *staff* information, and activity/event tracking across programs.

Merging, matching, or linking computer database records. Compiling information on individual clients stored in separate database files. A unique identifier (or identifiers) contained in *each* record (such as a *common* agency client number used across programs) is used to link records together across program database files.

Transfer versus "Open Access". Transfer of information is the electronic release of specific patient information from a family planning provider to another person or agency, for a specific purpose related to an individual patient's care, e.g., patient information accompanying a referral from family planning to Prenatal *Care* coordination. Open Access is the electronic release or storage of patient information into *shared* or common database files and records available to all users of the database (across multiple programs or projects) - and not immediately related to facilitating an individual patient's care.

APPENDIX A

DATA SYSTEM DIAGRAMS

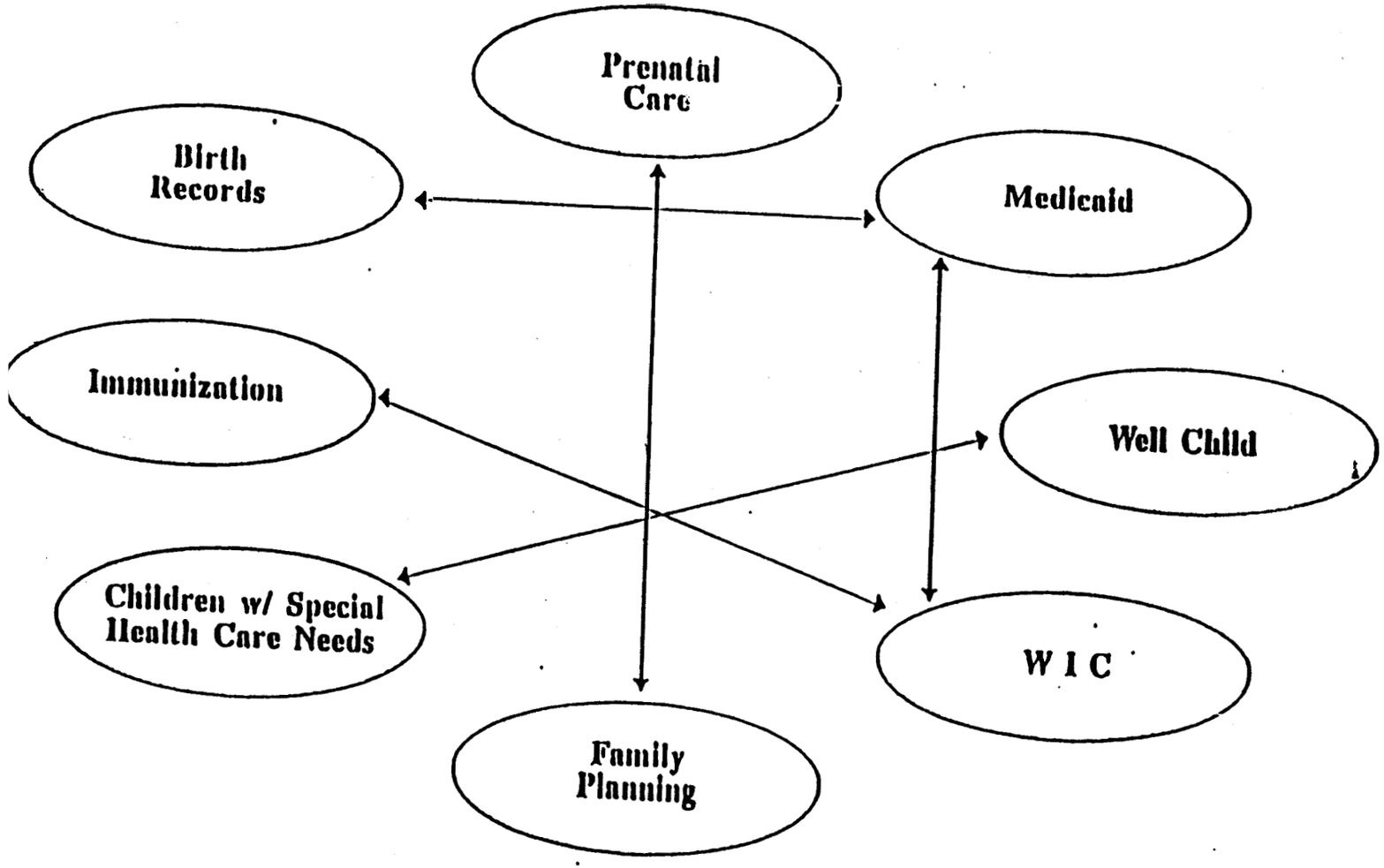
"Early Systems Linkages"

"Integrated System Model"

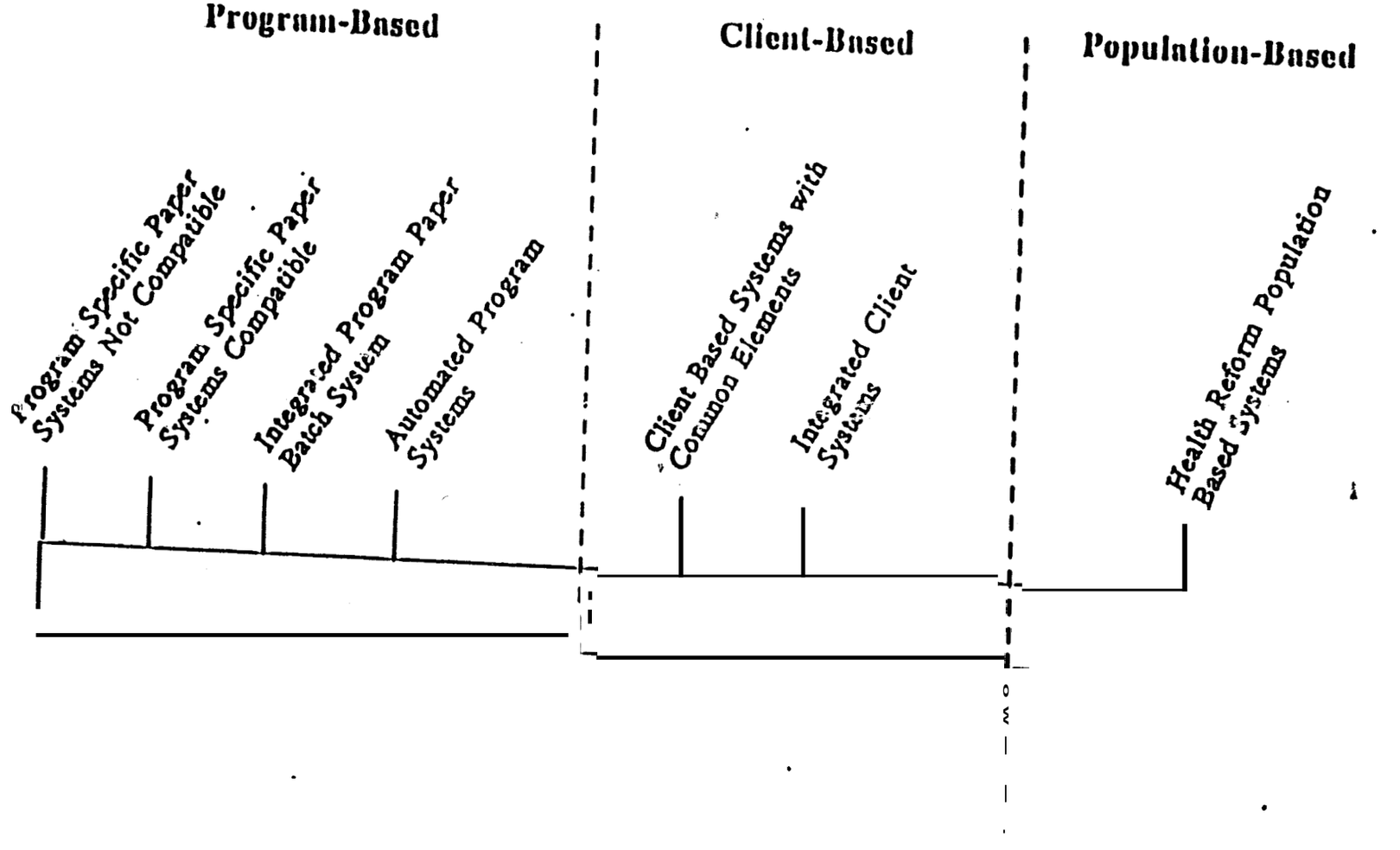
"Data Systems Evolution"

SOURCE
Health Systems Research, Inc.
Washington, DC

EARLY SYSTEMS LINKAGES



DATA SYSTEMS EVOLUTION



Attachment B Background Information

Wisconsin State Statutes and Administrative Code

All information gathered be any agency, entity or person conducting programs in *family* planning, *other* than statistical information compiled without reference to the identity of any individual or other information which the individual allows to be released through his or her informed consent, shall be considered a confidential medical record. 253.05(3)(c) Wisconsin Statutes.

All information gathered by the grant applicant as part of providing family planning services, other than statistical information compiled without reference to the identity of any individual, shall be released only with the informed *consent* of the individual for whom the services have been provided. HFS 151.03(2)(d) Wisconsin Administrative Code.

Reports, examinations, and inspections and all records concerning sexually transmitted diseases are confidential and not *open* to public inspection, and shall not be divulged except as may be necessary for the preservation of the public health, except.... [under commitment proceedings under sub. (5) or court ordered disclosure provided under s. 968.38(4)]. 252.11(7) Wisconsin Statutes.

Family Planning Patient Privacy and Confidentiality Policies

Access to Patient Information

Access to patient information is limited to personnel with formally delegated responsibility to provide family planning *core* services (or to supervisory personnel of family planning personnel) who are subject to formal disciplinary action for breech of confidentiality and privacy policies.

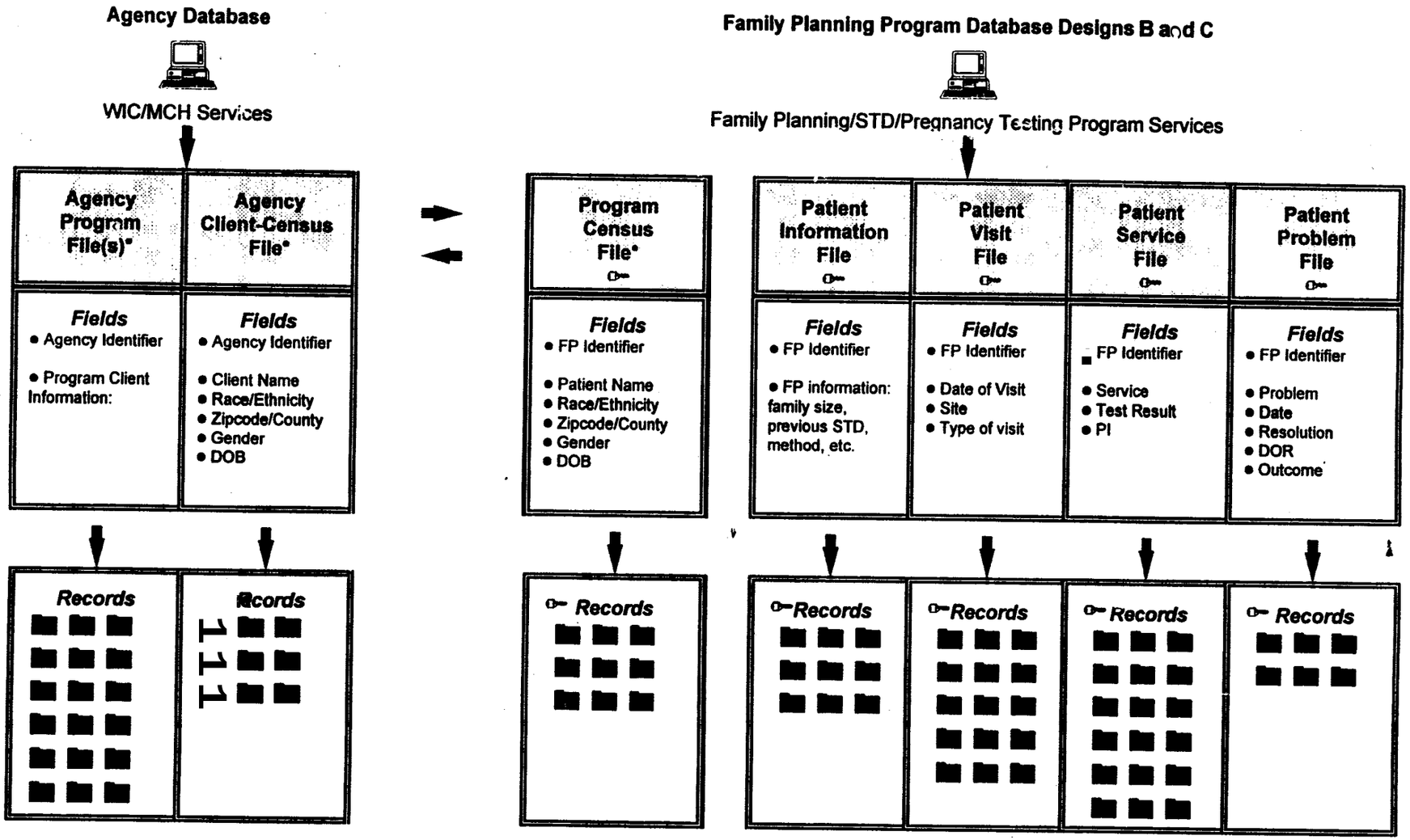
Patient information includes the *content* of patient records, or any *other* information that can directly or indirectly reveal the identity of an individual patient enrolled in the family planning program.

Release of Patient Information

Written and informed consent by a family planning patient is required prior to the release of any patient information whether or not in the form of a record (except as required by law) by any provider to *any* person or agency.

Written *consent* must meet all the criteria for proper *consent*, and must be obtained for each release of information.

Attachment D



* Import/Export of Patient Information only between the Family Planning Census File and the Agency Client-Census Database Files

Encrypted Data

Instructions for Completing Sexually Transmitted Diseases Morbidity and Epidemiologic Case Report DOH 4243 (Rec. 6/86)

General Instructions

This form should be used by all local public health agencies (LPHA) or other agencies conducting case/contact follow-up on reports of STD's. This form replaced the DOH 4064 (VDA) report. This form may be used in place of the DOH 4151 (i.e., when initiated from LPHA STD clinics, Family Planning, Planned Parenthood, or University Health Service Clinics) OR it may be used by the LPHA for case/contact follow-up when the DOH 4151 has already been received from a clinic or hospital. When used with the DOH 4151 this form need only repeat the name and birthdate from Sections A through D and any information that needs updating (e.g., change of address) or was missing (e.g., treatment date).

Send copy "A" and "B" to the "LPHA." Copy "A" will be sent to the State Epidemiologist by the LPHA. Copy "C" may be retained with the patient's record.

Specific Instructions

Section A: Case Identification: Answer all the questions as completely as possible.

Section B: Disease Episode Dates:

- Date of onset of symptoms -- indicate the date symptoms started *(for patients with symptoms)*.
- Date of clinic visit/or specimen collection -- indicate the date of the clinic visit for this disease or the date the specimen was collected for this episode of disease
- Confirmatory laboratory data -- indicate the type of test used to make this diagnosis and the result of this test.
- Comments -- add any comments you believe are pertinent.

Section C: Disease Classification:

Syphilis

Case definition: demonstration of *Treponema pallidum* by darkfield microscopy, clinical manifestations of acquired infectious syphilis and/or reactive serologic tests with no history of previous adequate treatment for syphilis.

Classification:

- Primary -- *Treponema pallidum* demonstrated by darkfield microscopy in material from a chancre or aspirate from a regional lymph node; *or* one or more typical lesions (chancres) and reactive nontreponemal tests in a patient, with no previous history of syphilis or reactive nontreponemal tests.
- Secondary -- signs of secondary syphilis and a newly-reactive serologic test *or* a greater than 4-fold increase in titer over the last known nontreponemal test.
- Early latent -- reactive nontreponemal and treponemal tests in an asymptomatic patient known to have had within the previous year: a reactive serologic test; *or* symptoms highly suggestive of primary or secondary syphilis; *or* exposure to a sex partner with definitive or presumptive primary, secondary, or early latent syphilis; *or* a greater than 4-fold increase in titer on serial nontreponemal tests.
- Late latent -- newly-discovered reactive nontreponemal and treponemal tests in an asymptomatic patient who does not meet the other criteria for early latent syphilis.

Gonorrhea

Case definition: demonstration of *Neisseria Gonorrhoeae* by gram stain and/or culture for males and by culture for females.

Classification:

- Asymptomatic -- no symptoms and no clinical signs of infection.
- Uncomplicated -- symptoms and/or clinical signs of infection.
- Salpingitis (PID) -- symptoms and clinical signs suggesting Pelvic Inflammatory Disease (PID), i.e., low abdominal pain or tenderness, adnexal tenderness, or cervical motion tenderness, with objective signs of an infection in the lower genital tract.
- Ophthalmia -- signs and/or symptoms of ocular inflammation or conjunctivitis.
- Penicillinase-producing *Neisseria Gonorrhoeae* (PPNG) -- definitive culture diagnosis for *Neisseria Gonorrhoeae* plus documented B-lactamase production.
- Tetracycline-resistant *Neisseria Gonorrhoeae* -- laboratory confirmed.
- Other (specify) -- specify other complications of a gonococcal infection, e.g., disseminated gonococcal infection (DGI), perihepatitis (Fitz Hugh-Curtis syndrome), prostatitis, acute epididymitis.

Chlamydial Infections

Case definition: demonstration of *Chlamydia trachomatis*, non-LGV strains, by tissue culture or direct test (e.g. direct fluorescent antibody or ELISA test). A patient with a negative culture and/or direct test, but a positive serologic test, should *not* be reported as a Chlamydia case.

Classification:

- Asymptomatic -- no symptoms and no clinical signs of infection.
- Uncomplicated -- symptoms and/or clinical signs of infection.
- Salpingitis (PID) -- symptoms and clinical signs suggesting PID (See gonorrhea section.)
- Ophthalmia/Conjunctivitis -- signs and/or symptoms of an inflammatory response.
- Other (specify) -- specify other complications of a chlamydial infection, e.g., pneumonia, acute epididymorchitis.

-- Specific Instructions Continued On The Back Of Copy B --

MANDATED REPORTING OF CHILD ABUSE AND NEGLECT

WHY MUST CHILD ABUSE AND NEGLECT BE REPORTED?
According to the Child Protective Service (CPS) Investigation Standards, their beliefs are: 1) All children deserve safety and a basic level of care. Public agencies have a responsibility to conduct thorough investigations in response to reports. 2) CPS is a social service intervention. The primary function of investigation is to identify families who require support and services to assure child safety and care. 3) When a child has been maltreated by an individual outside of the family, CPS should act as collaborators with and consultants to the parents.

WHAT MUST BE REPORTED?
Child abuse is defined as any physical injury inflicted on a child by other than accidental means; sexual intercourse or sexual contact with a child; sexual exploitation of a child; permitting, allowing or encouraging a child to be involved in prostitution; emotional damage inflicted on a child; or forcing a child to view sexually explicit activity.

Neglect is defined as failure, refusal or inability on the part of a parent, legal guardian, legal custodian or other person exercising temporary or permanent control over a child for reasons other than poverty, to provide necessary care, food, clothing, medical/dental care, and/or shelter to the child.

According to the law, specific professionals are mandated to report child abuse and neglect. The reporter must do so if they have reason to suspect that a child seen in the course of their professional duties has been abused, or neglected or threatened with abuse or neglect and that abuse or neglect will occur. Every instance of child abuse or neglect must be reported no matter when it happened or where it happened.

WHO MUST REPORT?
Wisconsin is considered quite progressive with regard to laws requiring professionals to report suspected child abuse or neglect. Sec. 48.981 (2), Wis. Stats., lists the many different professionals who are mandated reporters. Included among this list are e the following:

- mental health professionals
- social workers
- marriage and family therapists
- school teachers/administrators
- physician/nurse
- professional counselors
- administrators of social service agencies
- childcare provider, in or out of the child's home
- law enforcement officers
- physical therapist

Although, the law does not specifically list sexual assault program workers as mandated reporters, it is widely understood that such programs are intended to be mandated reporters.

In some programs, employees are told to report any suspected child abuse or neglect or a particular staff person. This staff person has the responsibility of contacting the local social services department or local law enforcement agency, as required by law. In other programs, workers are told to inform a client who gives information about child abuse or neglect that the program will notify social services and it would be best if the client reported the incident(s) before the program does so. The program gives the client a certain length of time in which to make the report and then contacts social services with the information.

WHAT HAPPENS AFTER A REPORT IS MADE?
Within 24 hours after receiving a report of abuse or neglect, the county CPS shall initiate an investigation to determine if the child is in need of protection or services. Elements of the investigation may include observation or interview with the child, visiting the child's home, or interviewing the parents/guardian. CPS can meet with the child in any place without the parent/guardian's permission, but may not enter the home without permission.

Source: WCASA's Sexual Assault Legal Advocate Manual, 1994, Chapter 48.981 of the Wisconsin Statutes, and Child Protective Service Investigation Standards, Dept. of Health and Social Services

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years. (b) A class D felony if the child has attained the age of 13 years but has not attained the age of 18 years. (s.948.055)

8) EXPOSING GENITALS OR PUBIC AREA. Whoever, for purposes of sexual arousal or sexual gratification, causes a child to expose genitals or pubic area or exposes genitals or pubic area to a child is guilty of a Class A misdemeanor. This section does not apply if the child is the defendant's spouse. (s.948.10)

9) SOLICITING A CHILD FOR PROSTITUTION. Whoever intentionally solicits or causes any child to practice prostitution or establishes any child in a place of prostitution is guilty of a Class BC *felony*. (s.948.08)

10) FEMALE GENITAL MUTILATION PROHIBITED. (1) In this section, "infibulate" means to clasp together with buckles or stitches. (2) Except as provided in *sub.* (3), no person may circumcise, excise or infibulate the labia majora, *labia* minora or clitoris or a female minor. (3) Subsection (2) does not apply if the circumcision, excision or infibulation is performed by a physician, as defined in s.448.01(5), and is necessary for the health of the female minor or is necessary to correct an anatomical abnormality. (4) None of the following may be asserted as a defense to prosecution or a violation of *sub.* (2): (a) Consent by the female minor or by a parent of the female minor to the circumcision, excision or infibulation. (b) The circumcision, excision or infibulation is required as a matter of custom or ritual. (5) Whoever violates *sub.* (2) *may* be fined not more than $10,000 or imprisoned for not more than 5 years or both. (s.146.35)

****

Penalties for a Class B felony (s.939.50(3)(b)) = imprisonment not to exceed 40 years.
Penalties for a Class BC felony (s.393.50(3)(c)) = a fine not to exceed $10,000 or imprisonment not to exceed 20 years, or both.
Penalties for a Class C felony (s.939.50(3)(c)) = a fine not to exceed $10,000 or imprisonment not to exceed 10 years, or both.
Penalties for a Class D felony (s.939.50(3)(d)) = a fine not to exceed $10,000 or imprisonment not to exceed 5 years, or both.
Penalties for a Class A misdemeanor (s.939.51(3)(a)) - a fine not to exceed $10,000 or imprisonment not to exceed 9 months, or both.

****

DEFINITIONS: "Child" means a person who has not attained the age of 18 years. "Person responsible for the child's welfare" includes the child's parent; stepparent; guardian; foster parent; an employee of a public or private residential home, institution or agency; any other person legally responsible for the child's welfare in a residential setting; or a person employed by one legally responsible for the child's welfare to exercise temporary control or care for the child. "Sexual contact" means any of the following: (a) Intentional touching by the complainant or defendant, either directly or through clothing by the use of any body part or object, of the complainant's or defendant's intimate parts if that intentional touching is either for the purpose of sexually degrading or sexually humiliating the complainant or sexually arousing or gratifying the defendant. (b) Intentional penile ejaculation of ejaculate or intentional emission of urine or feces by the defendant upon any part of the body clothed or unclothed of the complainant if that ejaculation or emission is either for the purpose of sexually degrading or sexually humiliating the complainant or for the purpose of sexually arousing or gratifying the defendant. "Sexual intercourse" means vulvar penetration as well as cunnilingus, fellatio or anal intercourse between persons or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal opening either by the defendant or upon the defendant's instruction. The emission of semen is not required. "Sexually explicit conduct" means actual or simulated:" (a) Sexual intercourse; (b) Bestiality; (c) Masturbation; (d) Sexual sadism or sexual masochistic abuse including, but not limited to, flagellation, torture or bondage; or (e) Lewd exhibition of intimate parts. (s.948.01)

Sources: Chapter 948 and s.939.50-51 of the Wisconsin Statutes

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RESPONSE TO REQUEST FOR RECORDS

DATE:

PATIENT:

We are returning your correspondence for the following reasons:

_____ Copies were sent _____. If you have not received them, please resubmit request

_____ Wisconsin Statues 146.81, 146.82, and 146.83 require an informed consent which MUST contain the following elements at the time it is signed. For your convenience, an informed consent is enclosed.

- _____ the name of the patient
- _____ the purpose of the disclosure in the body of the signed consent form
- _____ the type of information to be disclosed
- _____ the individual, agency or organization to which disclosure is to be made
- _____ the type of health care provider making the disclosure
- _____ signature of the patient (legal guardian if minor or incompetent)
- _____ date on which consent is signed
- _____ It is our policy to honor *only* those consents which are current and dated within 120 days of the date the request is received in our office. Please submit a current consent

_____ The consent does not meet the requirements of WI Statute 51.30 or federal law. Please have the patient complete the enclosed consent

_____ We require an *advance* payment of $5.00 to process your request for medical information. There will be an additional charge (50 *cents* per pate) if your request exceeds 10 pages. Please make check payable to

_____ We do not find record of the information you requested

_____ Additional information is needed to respond to your request

- _____ Date of birth
- _____ Maiden name
- _____ Clinic number
- _____ Other names under which patient was registered
- _____ Address
- _____ *Clarify* spelling of patient's name

_____ Other

_____

_____

Sincerely,

years. (b) A class D felony if the child has attained the age of 13 years but has not attained the age of 18 years. (s.948.055)

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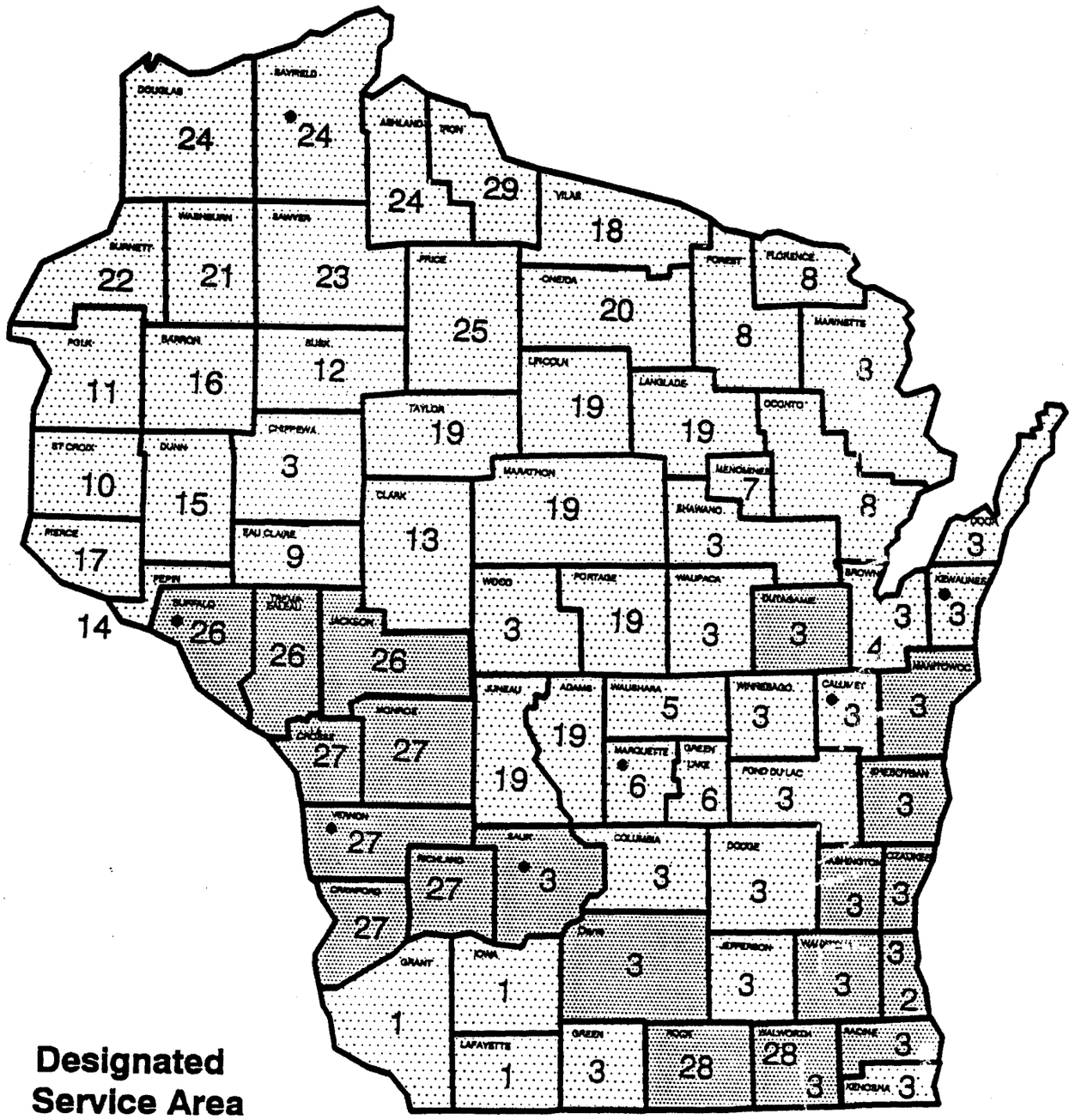
Wisconsin Family Planning Program



Designated Service Area

Title X

MCH/GPR

• **No Clinic In County**

Wisconsin Family Planning Program
Provider Service Areas and Clinic Locations

MCH Block Grant and GPR Service Area

Southwest WI Community Action Prc
165 W. Pine St.
Platteville, WI 53818
(608) 348-9766

Clinic (County)
H600 Platteville (Grant)
H601 Dodgeville (Iowa)
H602 Darlington (Lafayette)
H603 Fennimore (Grant)

Medical College of Wisconsin[2]
2040 West Wisconsin
Suite 507
MILWAUKEE WI 53233
(414) 935-5201

Clinic (County)
Milwaukee (Milwaukee)

Planned Parenthood of Wisconsin3
302 North Jackson Street
MILWAUKEE WI 53202-5917
Main Telephone Number:
(414) 271-8045

Clinic (County)
D182 Beaver Dam (Dodge)
D154 Chippewa (Chippewa)
D153 Eau Claire (Eau Claire)
D183 Fond du Lac (Fond du Lac)
D185 Fort Atkinson (Jefferson)
S132 Green Bay (Brown)
D121 Kenosha (Kenosha)
D132 Marshfield (Wood)
D104 Capitol Court (Milwaukee)
D195 Monroe (Green)
D142 New London
(Waupaca & Outagamie)
D141 Oshkosh (Winnebago)
D131 Shawano (Shawano)
D133 Sturgeon (Door)
S151 Wisconsin Rapids (Wood)

Calumet county'
Kewaunee county'

Oneida Community Health Center[4]
PO Box 365
ONEIDAWI 54155
(414) 869-2711

Area:
H930 Oneida Reservation

Family Health Medical and Dental Center[5]
400 South Townline Road, P.O. Box 1440
WAUTOMA WI 54982
(414) 622-4206

Clinic (County)
H941 Wautoma (Waushara)

Berlin Memorial Hospital[6]
225 Memorial Drive
BERLIN WI 54923
(414) 361-3771

clinic (County)
Berlin (Green Lake)

Marquette County'
Waushara County

Menominee Tribal Center'
PO Box 970
KESHENA WI 54135
(715) 799-3361

Ana
H770 Menominee Reservation

NEWCAP Inc[8]
1201 Main Street
OCONTO WI 54153
(414) 834-4621

Clinic (County)
H620 Marinette (Marinette)
H621 Crandon (Forest)
H622 Oconto (Oconto)
H623 Florence (Florence)

Eau Claire City-County Health Department[9]
720 Second Avenue
EAU CLAIRE WI 54703
(715) 839-4718

Clinic (county)
H501 Eau Claire (Eau Claire)

St Croix County **DHHS**[10]
1445 North **Fourth** Street
NEW RICHMOND WI 54017-6004
(715) 246-8366

clinic (County)
H710 New Richmond
H712 Hudson

Polk County Health **Department**[11]
300 Polkrusk county Plaza
BALSAM LAKE WI 54810
(715) 485-3161

Clinic (County)
H690 Balsam Lake (Polk)

Rusk County Health Department"
311 Miner Avenue East
LADYSMITH WI 54848
(715) 532-2177

Clinic (County)
H740 Ladysmith (Rusk)

Clark County Health Department[13]
517 Court Street
NEILLSVILLE WI 54456
(715) 743-5105

clinic (County)
H860 Neillsville (Clark)

Pepin County Health Department[14]
740 7th Avenue West PO Box 39
DURAND WI 54736-0039
(715) 672-5961

Clinic (County)
H930 Durand (Pepin)

Dunn County Health Department[15]
800 Wilson Avenue
MENOMONIE WI 54751
(715) 232-2388

clinic (County)
H760 Menomonie (Dunn)

Barron County Health **Department**[16]
1443 East Division Avenue
BARRON WI 54812
(715) 537-6279

Clinic (County)
H820 Barron (Barron)

Pierce County Health Department"
412 West Kinne PO Box 238
ELLSWORTH WI 54011
(715) 425-8003

Clinic (County)
H610 **Ellsworth** (Pierce)
H611 River Falls
H612 Elmwood

Vilas County Health **Services**[18]
226 HWY 70 PO Box 456
ST GERMAINE WI 54558
(715) 479-3357

Clinic (County)
H951 St. Germaine (Vilas)

Family Planning Health Services, **Inc.**[19]
719 **North** Third Avenue
WAUSAU WI 54401
(718) 675-9858

Clinic (County)
H660 Wausau (Marathon)
H661 Antigo (Langlade)
H663 Stevens Point (Portage)
H664 Medford (Taylor)
H665 Friendship (Adams)
H666 Mauston (Juneau)
H667 Tomahawk (Lincoln)

Oneida County Health Department[20]
Courthouse PO Box 400
RHINELANDER WI 54501
(715) 369-6116

Clinic (County)
H720 Rhinelander (Oneida)

Washburn County Health Department[21]
222 Oak *Street*
SPOONER WI 54801
(715) 635-7616

Clinic (County)
H630 Spooner (Washburn)
H631 Minong
H632 Birchwood
H633 Shell Lake

Burnett County Health Department[22]
7410 County Road K # 114
SIREN WI 54872
(715) 349-2141

Clinic (County)
H640 Siren (Burnett)

Sawyer county Health Department[23]
105 *East* Fourth St., PO Box *528*
HAYWARD WI 54843-0528
(715)634-4874

Chic (County)
H750 Hayward (Sawyer)

Health Care **Clinic**[24]
2231 Catlin Avenue
SUPERIOR WI 54880
(715) 394-4117

Clinic (County)
H680 Superior (Douglas)
H682 Ashland (Ashland)

Bayfield County.

Price County Health Department[25]
104 South Eyder Avenue
PHILLIPS WI 54555
(715) 399-3054

Clinic (County)
H730 Phillips (Price)

Iron County **Health** Department[29]
502 Copper Street
HURLEY WI 54534
(715) 561-2191

Chic (County)
H683 Hurley (Iron)

County Outstationing Map

(A list of outstation sites is on **the** back of this map.)

County worker outstationed on-site

Disproportionate share hospital, federally qualified health center (FQHC), or tribal outstation site(s)

No currently operating outstation sites

Wisconsin Department of Health and Family **Services**
Division of Health Care Financing
POH 1103 May 1999

Wisconsin Family Planning Program Education and Training Project
Overview

The purpose of the project is to provide training, continuing education, and technical assistance to publicly funded family planning programs in Wisconsin in order to improve and maintain the quality and cost-effectivenessof services through community-based family planning programs.

Assumptions for an effective project include the following:

Training, continuing education, and technical assistance needs to be: • provided to new staff and experienced personnel, based on the training needs identified by local programs; • delivered in a cost-effective manner with minimum impact on clinic operations and staff time; • coordinated and integrated with Title X, and other DHFS training related to family planning and reproductive health whenever feasible; and • accessible and affordable for all Title X, Title V, or GPR-funded family planning programs.

Community-based family planning programs need to be involved in assessment, planning and implementation of training, continuing education, technical assistance, and other support services.

Training, continuing education, and technical assistance needs to utilize an array of appropriate and cost-effective methodologies and approaches including traditional and distance learning-based classes, self-guided study (Internet-web based and printed materials); seminars (satellite and teleconference); central, regional-based, and on-site locations; and utilization of the Annual Family Planning/Reproductive Health Conference.

Technical assistance needs to include a range of approaches including utilization of a Web Page for reference materials, interactive approaches to self-guided learning, Frequently Asked Questions (FAQs), Questions to Trainers for individualized assistance to community-based family planning programs; technical paper/reports; and on-site consultation.

A training plan and schedule needs to be designed and developed for training, continuing education, and technical assistance meeting nationally recognized curriculum and practice guidelines and based upon needs identified by community-basedprograms in relation to DPH-Family Planning Program contract requirements and quality criteria, including the following key areas:

Project Training Activities

Obtain and coordinate nurse practitioner training through certificate programs on behalf of publicly funded family planning programs in Wisconsin. Arrange and coordinate preceptorship sites as needed for nurse practitioners in training. Provide tutorial support for nurse practitioners in training through their certification.

Provide training (individualized or organized, on-site or distance learning options) for nurse practitioners to obtain certification for contraceptive management and related reproductive health.

Provide individualized training programs for members from minority communities working in community-based family planning programs as nurse practitioners, registered nurses, clinic assistants, educators, or community educators.

Organize and provide training programs in specialized areas for nurse practitioners including: contraceptive management programs leading to secondary GYN certification for practitioners trained in field other than Women's Health and OB/GYN, and advanced training for nurse-colposcopy practice.

Project Continuing Education Activities

Organize continuing education for clinic and community education personnel in publicly supported family planning programs including the following key areas:

- management and short-term care coordination of patients with abnormal pap tests;
- family planning/reproductive health privacy and confidentiality (patient rights and provider responsibilities);
- STD services with emphasis on Chlamydia based upon the Region V Infertility Prevention Guidelines including risk assessment, patient education, interviewing and disease intervention, and partner intervention);
- contraceptive services;
- pregnancy testing services;
- quality assurance; and
- implementation of services under the proposed Medicaid Family Planning Waiver to expand eligibility for family planning services.

Organize continuing education in relation to key practice areas identified in the Family Planning/Reproductive Health/EIDP Quality Criteria including:

- pregnancy testing;
- emergency contraception:
- prescription contraception with option of deferred physical examinations and laboratory services;
- confidentiality); and
- practice in compliance with recognized standards identified in the Family Planning/Reproductive Health/EIDP Quality Criteria.

Provide continuing education credits and certificates of completion needed to meet certification requirements of family planning program personnel, and formal documentation of training plans.

Priority training and continuing education issues include: • services to adolescents; • family planning/reproductive health/pregnancy test patient privacy and confidentiality rights (as defined by the Quality Criteria) and provider responsibilities; and • sexual abuse/sexual assault issues.

Project Technical Assistance and Support Activities

Organize technical assistance to promote quality services and compliance with the Family Planning/Reproductive Health/EIDP Quality Criteria by community-based family planning programs.

Organize and provide access to relevant reference materials and practice guidelines in relation to key practice areas identified in the Family Planning/Reproductive Health/EIDP Quality Criteria including:

- management and short-term care coordination of patients with abnormal pap tests;
- family planning/reproductive health privacy and confidentiality (patient rights and provider responsibilities);
- STD services with emphasis on Chlamydia based upon the Region V Infertility Prevention Guidelines (including risk assessment, patient education, interviewing and disease intervention, and partner intervention);
- contraceptive services (including emergency contraception);
- pregnancy testing services;
- quality assurance;
- prescription contraception with option of deferred physical examinations and laboratory services;
- confidentiality); and
- standards and guidelines of care identified in the Family Planning/Reproductive Health/EIDP Quality Criteria and recognized in the field of family planning.

Provide updated family planning and related reproductive health policy and protocols, training, and technical assistance to Title X, Title V, or GPR-funded family planning providers to be used as a reference in development of prograndclinic-specificpolicies. Provide updated family planning and related reproductive health quality assurance materials, training, and technical assistance to Title X, Title V, or GPR-funded family planning providers.

Provide technical assistance with procurement of low-cost supplies.

Provide updated materials, training, and technical assistance to Title X, Title V, or GPR-funded family planning providers as part of the Region V/Wisconsin Infertility Prevention Project. Coordinate and provide technical support to surveillance sites as part of the Region V/Wisconsin Infertility Prevention Project linked with the **STD** Program, Family Planning Program, and the State Laboratory of Hygiene.

The purpose of the Infertiity Prevention Project is to monitor and measure rates of infection, chlamydial infection risk factors within the family planning patient population, the sensitivity of high-risk screening criteria for identifying patients at high-risk of infection, index patient and contact treatment rates, and intervention methods for patients at high-risk of reinfection.

Provide supplies to support infertility prevention services. Procure and distribute medications and supplies to all Title X, Title V, or GPR-funded family planning programs for treatment of patients diagnosed with chlamydial infection and their partners. Develop, update and maintain, and distribute chlamydia-related risk assessment and patient education materials to family planning programs as part of the Infertility Prevention Project.

Appendix C

Wisconsin estimates by the Alan Guttmacher Institute[1]

Number of women ages 13-44	1,199,350
Total needing contraceptive services and supplies	625,000
Women needing publicly supported contraceptive services	**296,390**
Number under age 18	45,820
Number under age 20	92,060
Women ages 20-44	
Number under 100% poverty	68,970
Number under 150% poverty	105,830
Number under 185% poverty	133,030
Number under 250% poverty	204,330

Approximately 25.6 percent of the total estimated need (women needing publicly supported contraceptive services) was served in 1995 through the Wisconsin Family Planning Program. An estimated 36% and 51% of total estimated need was served through all publicly supported health facilities.

Approximately 86,493 women ages 20-44 needing publicly supported services and below 185% of poverty did not receive services through the Wisconsin Family Planning Program in 1995. Approximately 17,501 patients under age 20 (among the 92,060 estimated in need) also received through the Wisconsin Family Planning Program in 1995.

Assuming 51% of the total estimated need below 185% of poverty (between ages 20-44) was served through all publicly supported health facilities in 1995, then 65,185 women ages 20-44 and below 185% remained unserved in 1995. This does not include estimates of adolescents under age 20 unserved: 46,470 of women below age 20 (estimated in need of services) were not served through publicly supported health facilities (including but not limited to the Wisconsin Family Planning Program).

[1] The Alan Guttmacher Institute. *Contraceptive Needs and Services*, New York, *1995.*

Title V/GPR Family Planning and Related Reproductive Health Care (including EIDP)
Standard of Practice Inventory

Standard of Practice **Review The Agency's Readiness with Each Requirement as of January 1, 2000** **Provide Explanation for Each No Response**	**Agency/Program Practices in Compliance with Requirements?**		**Policies and Protocols Address Requirements?**		**Quality Assurance Systems to Monitor and Ensure Compliance?**	
Section 1: Assessment and Surveillance	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
Family planning programs must develop a county/community plan for family planning services and related reproductive health services as required by s. 253.07., Wisconsin Statutes.						
The plan must: • be based on a community needs assessment; • place emphasis upon women at highest risk of unintended pregnancy; • contain realistic goals and objectives, and measurable action steps to achieve its purpose; • involve key community health providers; • contain criteria and standards which define "reasonable" accessibility and availability for the community; • identify indicators of effectiveness commonly used within the field of family planning to evaluate the community system of services; • define steps to ensure effective outreach to patients newly eligible for services under the Medicaid family planning waiver; • define steps to ensure an effective, efficient, and patient responsive community system for presumptive eligibility determination, and enrollment and re-enrollment of patients; and • define community standards for effective pathways for essential services.						
Local health departments should be provided the opportunity: to engage in their public health assurance role to assure community access to affordable and quality family planning services, and to assure availability of community-based family planning services.						
Public health departments should be provided the opportunity to collaborate with family planning programs, and (to) develop, implement, and evaluate a county/community plan to assure an effective community-based system of family planning services.						

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Section 2: Delivery of Services	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
Family planning programs must provide contraceptive services (emergency and on-going methods) and related-reproductive health services.						
Related reproductive health services must include: • reproductive health screening and assessment services; • sexually transmitted disease screening and assessment, diagnosis and treatment, and disease intervention services; and • pregnancy testing, risk assessment, and early pregnancy care services.						
Services must comply with established standards and program requirements which define the content of patient care and the provision of services.						
Family planning programs must provide: family planning and related reproductive health patient education and anticipatory guidance, presumptive eligibility, and short-term care coordination services. (Presumptive eligibility includes Healthy Start enrollment and enrollment under the proposed expansion of Medicaid family planning eligibility).						
Services must be designed to facilitate: • prevention of unintended pregnancy; • timely continuity of patient care at critical reproductive health events (appropriate for reproductive health needs and risks, family planning goals, pregnancy plans, and pregnancy status); • reproductive health risk reduction; and • reproductive health promotion.						
Services must comply with established standards and program requirements which define the content of patient care and the provision of services.						
Policy, procedure, and protocol manuals must specifically address continuity of care. Timely continuity of care must be included in the Quality Assurance and chart audits.						
Family planning programs must have clinic-based services.						
The preferred standard are provision of all on-site clinical, laboratory, and contraceptive services with the availability of nurse practitioners staffing.						

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Section 2: Delivery of Services	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
Family planning programs must maintain the following minimum configuration of clinic services: • staffed by registered nurse; • maximum availability of on-site pregnancy testing services; • maximum availability (within the constraints of costs and available funding) of on-site Emergency Hormonal Contraception (EHC); • on-site prescription contraception with the option to defer medical/laboratory services; • on-site prescription supplies; • on-site non-prescription supplies; • on-site STD testing (gonorrhea, chlamydia, syphilis, and herpes) and treatment (gonorrhea and chlamydia); • reasonable access and waiting period for provision of on-site or off-site physical examinations and laboratory tests.						
All clinic services must be provided within the context of. • a community plan (as part of public health's assurance function) to assure access to affordable and quality family planning and related reproductive health services by residents; • an organized public information and education, and outreach program; • patient education and anticipatory guidance; and • short term care coordination.						

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Section 2: Delivery of Services	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
Family planning programs must provide immediate contraception to patients at risk of unintended pregnancy. This includes: • Emergency Hormonal Contraception (EHC), • Prescription contraceptives with opportunity for deferred physical examination and laboratory services, and • non-prescription contraception.						
The **content of patient care** and the **provision of services** within family planning programs must comply with: • Wisconsin Administrative Code at Chapters 105 and 107 (Medical Assistance), and the current Title X Program Guidelines **(as edited to ensure necessary and sufficient standards for quality care and cost-effective services)**; • DHFS's Guidelines for Perinatal Care: Preconceptional Health Services; • Patient Rights and Provider Responsibilities: Privacy and Confidentiality Issues for Family Planning and Reproductive Health Services - A Resource Guide for the Wisconsin Family Planning Program (to ensure patient privacy rights and consumer confidence in confidentiality safeguards for all patient information); and • Region V Infertility Prevention Guidelines.						
The **content of patient care** and the **provision of services** within family planning programs must be consistent with **current** established professional standards and guidelines within the field of family planning including: American Academy of Obstetricians and Gynecologists (ACOG) Women's Health Guidelines, Contraceptive Technology, and Planned Parenthood Federation of America Medical Services Guidelines.						
Family planning programs must submit pap smears and Chlamydia tests (and any other tests subsidized under contracts between the Division of Public Health - Family Planning Program and the WSLH) to the Wisconsin State Laboratory of Hygiene for all patients receiving clinical services at the family planning program.						
Use of other laboratories for pap smears and Chlamydia tests for family planning patients require formal approval of a written request. Assurances of equivalent quality standards and surveillance data reports will be required. MCH and GPR funds and patient fees must not be used to subsidize these tests at other laboratories.						

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Section 3: Record Keeping	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
Family planning programs must establish policies and procedures to protect and safeguard family planning patient privacy and confidentiality rights. (See **Provision of Guidance** section).						
Family planning program patient confidentiality and privacy policies and procedures must conform to the following standard for access to and release of patient information: *Access to Patient Information* Access to patient information is limited to personnel with formally delegated responsibility to provide family planning core services (or to supervisory personnel of family planning personnel) who are subject to formal disciplinary action for breech of confidentiality and privacy policies. Patient information includes the content of patient records, or any other information that can directly or indirectly reveal the identity of an individual patient enrolled in the family planning program. *Release of Patient Information* Written and informed consent by a family planning patient is required prior to the release of any patient information whether or not in the form of a record (except as required by law) by any provider to any person or agency. Only family planning providers have direct access to family planning patient information: prior written informed consent is required for release of information to other individuals (including other personnel within a parent organization) or agencies. Written consent must meet all the criteria for proper consent, and must be obtained for each release of information.						
Family planning programs must comply with regulations and guidelines which define the requirements for the content of patient records. Local agency and program policies must define: the content, storage and retrieval, security, and personnel access to patient health care records and patient information specific to family planning services.						

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Section 4: Information, Education, and Outreach	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
Family planning programs must provide family planning and related reproductive health public information and education, and outreach services.						
Services must: • be designed to increase awareness and understanding among all women of child bearing age of family planning and related reproductive health care issues and where to obtain services; • place particular emphasis on reaching population segments at higher relative risk of unintended pregnancy and reproductive health morbidity; and • be designed to successfully implement the anticipated Medicaid family planning waiver.						
Family planning issues and services include: contraception (including emergency contraception); early pregnancy testing; patient privacy and confidentiality rights; infertility prevention and other reproductive health risk reduction; and reproductive health promotion.						

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Section 5: Coordination	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
Family planning programs must be coordinated with other DHFS programs and initiatives including: services under the proposed Medicaid family planning waiver; Brighter Futures Healthy Start; Prenatal Care Coordination; and Turning Point.						
Family planning programs must be designed to contribute to the applicable goals and recommendations within the DHFS Brighter Futures Implementation Plan including: • free (or low cost) walk-in pregnancy testing services with immediate access to contraceptive services; • provide Healthy Start Presumptive Eligibility Determination Services; and • have established linkages with PNCC and other pregnancy services to facilitate timely access to services.						
Family planning programs must provide services under the Medicaid Family Planning Waiver including: • outreach; • presumptive eligibility determination services; and • enrollment follow-up to facilitate enrollment during the PE period.						

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Section 6: Referral Network	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
Family planning programs must establish referral networks that provide effective pathways for essentials services and facilitate time continuity of patient care at critical reproductive health events. See standard requiring a county/commutity plan under **Assessment and Surveillance**: "The plan must: ...• define community standards for effective pathways for essential services." See description of short-term care coordination services required under **Delivery of Services**: "Services must be designed to facilitate:...• timely continuity of patient care at critical reproductive health events (appropriate for reproductive health needs and risks, family planning goals, pregnancy plans, and pregnancy status)...".						

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Section 7: Provision of Guidance	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
Family planning programs must maintain an up-to-date policy, procedure, and protocol manual.						
Manuals must contain program specific protocols and procedures to implement the established standards of care and program requirements.						
Manuals must be periodically reviewed for completeness by the local family planning program: *current standards and guidelines recognized in the field of* family planning should be used as a reference.						
Family planning programs must develop, maintain, and monitor compliance with policies and procedures that comply with requirements of patient confidentiality and privacy standards established by the Division of Public Health - Family Planning Program. Local agency and program policies must define the content, storage and retrieval, security, and personnel access to patient health care records ad *patient information specific to family planning patient privacy and confidentiality.* Policies must also define procedures for release of patient information.						
Family planning programs patient confidentiality and privacy policies and procedures must comply with the following requirements: "All information gathered by any agency, entity or person conducting programs in family planning, other than statistical information compiled *without reference to the identity of any individual or other information which the individual allows to be released through his or her informed* consent, shall be considered a confidential medical record." **Wisconsin Family Planning Statutes at s. 253.07(3)(c).** "Reports, examinations, and inspections and all records concerning sexually transmitted diseases are confidential and not open to public inspection, and shall not be divulged except as may be necessary for preservation of the public health . . ." ***Confidentiality requirements* for sexually transmitted disease (STD) services defined at s. 252.11(7).** "All information as to personal facts and circumstances . . . must be held confidential and must not be disclosed without the individual's consent, except as may be required to provide services to the patient or as required by law." Only summary statistical information that does not identify individuals may be released. The Family Planning Services and Population Research Act (Public Law 91-572), was enacted in 1970 adding Title X - Population Research and Voluntary Family Planning Programs: **42 CFR, Sub-part A, Part 59, §59.11** - Confidentiality, published in the Federal Register, Vol.45, No. 108, Tuesday, June 3, 1980. "All personal information obtained shall be treated as privileged communication, shall be held confidential, and shall be divulged only upon the recipient's written consent except when necessary to provide services to the individual or to seek reimbursement for the services. The agency director shall ensure that all participating agencies preserve confidentiality of patient records. Information may be disclosed in summary, statistical or other form which does not identify specific recipients." HHS 105.36 (2)(g). WI Administrative Code. Medical Assistance. Family planning clinics or agencies. Guidelines within Patient Rights and Provider Responsibilities: Privacy and Confidentiality Issues for Family Planning and Reproductive Health Services - A Resource Guide for the Wisconsin Family Planning Program.						
Family planning programs must have an annual independent programmatic audit using a uniform audit tool.						

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Section 7: Provision of Guidance	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
Family planning programs must develop, maintain, and implement a plan for quality assurance audits and chart reviews.	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
Quality assurance audits and chart reviews must be performed periodically according to the plan to determine compliance with key standards, protocols, and procedures. Quality assurance audits must include tracking high risk clients, tracking abnormal laboratory test results, and occurrence reporting.						
A summary of each quality assurance audit and chart review must be prepared, describing the process, specific objectives, findings, and any resulting corrective actions or policy/procedures changes. Results of quality assurance audits and chart reviews must be available for review by Contract Administrators during monitoring visits and for program audits.						
Family planning programs must perform periodic client satisfaction surveys to obtain feedback on the accessibility, affordability, acceptability, and convenience of services.						
Family planning programs must perform periodic internal audits to evaluate patient services and policies, and to enhance program responsiveness to patients.						
A summary of each survey must be prepared, describing the process, specific objectives, findings, and any resulting changes. Results of the survey must be available for review by the Contract Administrator during monitoring visits and for program audits.						

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Section 8. Financial Management Practices	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
The statewide family planning program must be accounted for as a distinct statewide program as required at s. 253.07.						
family planning programs must maintain a separate budget for family planning program expenses and revenue.						
Family planning programs must have an independent financial audit performed at least bi-annually by certified public accountants following generally accepted accounting principles, either separately or as part of a single audit.						
Family planning programs must screen all patients receiving services for third party health coverage (private and coverage under the Medical Assistance Program).						
Patient services in family planning programs consist of the following components: 1) screening and assessment; 2) education, counseling, and care plan management; 3) diagnostic laboratory procedures; 4) examinations and diagnostic clinical procedures, and 5) treatment (contraceptive and therapeutic supplies and procedures).						
Family planning programs must privide services in components 1 and 2 without charge to self-supported clients with incomes below 100% of the poverty level. Fees can be charged to self-supported clients with incomes below 100% of the poverty level (if not enrolled in the proposed Medicaid family planning waiver) for all other services in components 3-5.						
Family planning programs must provide "No-Charge" and "Fee-Exempt" tests available through the Wisconsin State Laboratory of Hygiene (WSLH) only to patients enrolled in the family planning program who meet the current eligibility criteria established by the Division of Public Health - Family Planning Program.						
"No-charge" chlamydia tests are available through the WSLH for all STD contacts of family planning patients. Patients receiving "No-Charge" and "Fee-Exempt" tests through the WSLH must not be charged for the laboratory tests.						
All charges in family planning programs must be based on a sliding fee (discount) schedule.						

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Section 8. Financial Management Practices	**YES**	**NO**	**YES**	**NO**	**YES**	**NO**
Family planning programs must document in the local agency's policy, procedure, and protocol manual: the method for identifying cost components and establishing patient fees, the method for establishing fee levels, and developing the sliding fee schedule (discounts). Cost accounting must be subject to financial audits to verify validity and accuracy.						
MCH/GPR grant funds must not be used to subsidize the office visit (including the physical examination, health history, and costs related to testing and treatment) of male STD contacts of patients. ("No-charge" medications for treatment are available for all STD contacts of family planning patients. See WSLH section under **Delivery of Services**.)						
Program generated revenue earned in excess of program costs can be retained by the family planning program but must be used in following contract years to maintain or extend services.						
Fees and charges must be consistent with three guidelines: 1) Services should as affordable as possible for all patients, within the constraints of costs and funding; 2) No patient can be denied services due to an inability to pay; and 3) Flexible payment arrangement must be available to help patients pay their fees, e.g., deferred payment and installment arrangements. Sliding fee (discount) schedules must be developed with the primary goal of making services as affordable as possible for patients, within the constraints of the cost of services and funding.						
Family planning programs must use the most current Poverty Income Guidelines, published by the Department of Health and Human Services for patient eligibility determination, and data reporting requirements.						
Laboratory specimens and laboratory request forms must be submitted to the WSLH under the accounts specified in the current instructions developed by the DPH - Family Planning Program.						